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Commission on Population and Development
Forty-third session
12-16 April 2010
Item 2 of the provisional agenda
Adoption of the agenda and other organizational matters

Provisional agenda

1. Election of officers.
2. Adoption of the agenda and other organizational matters.
3. Actions in follow-up to the recommendations of the International Conference on Population and Development.
4. General debate on national experience in population matters: health, morbidity, mortality and development.
5. Programme implementation and future programme of work of the Secretariat in the field of population.
6. Contribution of population and development issues to the theme of the annual ministerial review in 2010.
7. Provisional agenda for the forty-fourth session of the Commission.
8. Adoption of the report of the Commission on its forty-third session.

Annotations

1. Election of officers

Rule 15 of the rules of procedure of the functional commissions of the Economic and Social Council stipulates that the Commission shall elect, from among the representatives of its members, a Chair, one or more Vice-Chairs and such other officers as may be required.

In accordance with its decision 2004/2, the Commission, immediately following the closure of its forty-second session, held the first meeting of its forty-third session for the sole purpose of electing the new Chair and other officers of the Commission. The following officers were elected: Chair: Daniel Carmon (Israel); Vice-Chairs: Eduardo Rios-Neto (Brazil), Shoji Miyagawa (Japan), Agnieszka Klausa (Poland)

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and Lizwi Nkombela (South Africa). The membership of the Commission at its 43rd session is provided in the annex.

2. Adoption of the agenda and other organizational matters

Rule 7 of the rules of procedure of the functional commissions of the Economic and Social Council requires that the Commission shall, at the beginning of each session, adopt the agenda for that session on the basis of the provisional agenda.

On the recommendation of the Commission at its forty-second session, the Council, in its decision 2009/239, approved the provisional agenda and documentation for the forty-third session of the Commission.

At its thirtieth session,[1] the Commission decided to authorize its Bureau to hold intersessional meetings in preparation for its sessions on a yearly basis. At its thirty-ninth session, in its resolution 2006/1,[2] the Commission requested its Bureau to meet as frequently as necessary in preparation for its annual sessions. The Commission has before it the report of the Bureau on its intersessional meetings.

Documentation

Provisional agenda (E/CN.9/2010/1)

Report of the Bureau of the Commission on Population and Development on its intersessional meetings (E/CN.9/2010/2)

Note by the Secretariat on the organization of work of the session (E/CN.9/2010/L.1)

3. Actions in follow-up to the recommendations of the International Conference on Population and Development

In its resolution 49/128, in which it endorsed the recommendations of the International Conference on Population and Development, the General Assembly decided that the Commission, as a functional commission assisting the Economic and Social Council, would monitor, review and assess the implementation of the Programme of Action of the Conference at the national, regional and international levels and advise the Council thereon.

In the terms of reference of the Commission,[3] which were endorsed by the Council in its resolution 1995/55, the Commission was called upon to adopt a topic-oriented and prioritized multi-year programme. That work programme, inter alia, would provide a framework for assessing the progress achieved in the implementation of the Programme of Action. In its report on its twenty-eighth session, of which the Council took note in its decision 1995/236, the Commission called for the preparation of annual reports on a selected topic of the Programme of Action.[4]

At its twenty-first special session, the General Assembly, in its resolution S-21/2, adopted the key actions for the further implementation of the Programme of Action.

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[1] *Official Records of the Economic and Social Council, 1997, Supplement No. 5* (E/1997/25), para. 52.

[2] Ibid., *2006, Supplement No. 5* (E/2006/25), chap. I.B.

[3] Ibid., *1995, Supplement No. 7* (E/1995/27), annex I, sect. I.A.

[4] Ibid., sect. III.

In its decision 2008/101,[5] the Commission decided that the special theme for the forty-third session in 2010 should be "Health, morbidity, mortality and development".

Documentation

Report of the Secretary-General on world population monitoring, focusing on health, morbidity, mortality and development (E/CN.9/2010/3)

Report of the Secretary-General on the monitoring of population programmes, focusing on health, morbidity, mortality and development (E/CN.9/2010/4)

Report of the Secretary-General on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (E/CN.9/2010/5)

4. General debate on national experience in population matters: health, morbidity, mortality and development

The Commission has concluded that it would be useful to make provision in its agenda for a general debate on population matters relating to the topic of the Commission's focus, during which Government views and national experiences could be exchanged.

5. Programme implementation and future programme of work of the Secretariat in the field of population

At its twenty-eighth session,[6] the Commission suggested that the work programme in the field of population should continue, inter alia, to give high priority to the monitoring of population trends and policies and include the biennial preparation of estimates and projections of global, national, urban, rural and city populations; the conduct of studies on population and related development policies; the preparation of studies on interactions of population change with other development processes; the conduct of analyses of mortality; contribution to and coordination of in-depth studies on fertility, nuptiality and reproductive rights and health, including family planning; the conduct of studies to improve the understanding of the causes and consequences of internal migration and international migration; increasing public awareness of and information exchange on population and development issues; making the necessary arrangements for coordinating the review and appraisal of the Programme of Action; and the provision of technical cooperation support to developing countries, particularly the least developed countries, and, on a temporary basis, to countries with economies in transition in the light of the economic and social problems that those countries faced at that time.[7]

The Commission reaffirmed the content of the work programme at its twenty-ninth session (Commission resolution 1996/1).[8]

At its thirtieth session, the Commission stressed the importance of continuing the basic work of the Population Division of the Secretariat on the crucial

[5] Ibid., *2008, Supplement No. 5* (E/2008/25), chap. I.B.

[6] Ibid., *1995, Supplement No. 7* (E/1995/27), annex II.

[7] Ibid., annex II.

[8] Ibid., *1996, Supplement No. 5* (E/1996/25), chap. I.C.

underpinnings of population estimates and projections; basic population trends and issues, including fertility, mortality, migration and patterns of rural and urban population change; the evolution of population policies; and understanding of the links between population and development (Commission resolution 1997/3).[9]

At its thirty-seventh session, the Commission reaffirmed the importance of the work of the Population Division in providing the United Nations system and the international community with comprehensive and scientifically sound inputs for the analysis of progress made in achieving the goals and objectives on population and development set in the outcomes of major United Nations summits and conferences, especially the Programme of Action of the International Conference on Population and Development, the key actions for its further implementation and the Declaration of Commitment on HIV/AIDS (Commission resolution 2004/1).[10]

At the same session, the Commission further emphasized that the Population Division should continue basic work on population estimates and projections; patterns of rural and urban population change; the analysis of international migration; the implications of the changing age structure of the population for development; the increasing diversity of fertility and mortality levels and trends; the interrelations among population, resources, the environment and development; and the evolution of population policies, applying a gender perspective in this regard (Commission resolution 2004/1).[10]

As indicated in the strategic framework for the period 2010-2011,[11] the objective of the subprogramme on population is to strengthen the international community's capacity to effectively address current and emerging population issues and to integrate the population dimensions into the development agenda at the national and international levels. In paragraph 7.12 of the strategic framework, the Population Division was designated as the entity responsible for the subprogramme, and the Division was mandated to achieve that objective by: (a) providing substantive support to United Nations bodies, especially to the Commission, and assessing progress made in the implementation of the Programme of Action of the International Conference on Population and Development and the achievement of the Millennium Development Goals; (b) facilitating the discussion of key or emerging population issues by experts or Government representatives; (c) preparing comprehensive studies on population issues and population trends relating to fertility, mortality, international and internal migration, HIV/AIDS, urbanization, population growth, population ageing, population prospects, population policy and population in relation to development; (d) disseminating population information and policy-relevant findings in the area of population, in particular through the Population Division websites; and (e) building capacity to address population issues at the national level through workshops or the dissemination of technical material, such as manuals and software.

The Commission has before it for consideration a note by the Secretary-General on the proposed strategic framework for the period 2012-2013 for subprogramme 6, Population, of programme 7, Economic and social affairs. The Commission is invited to review the proposal and provide its comments thereon. The proposed

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[9] Ibid., *1997, Supplement No. 5* (E/1997/25), chap. I.C.

[10] Ibid., *2004, Supplement No. 5* (E/2004/25), chap. I.B.

[11] *Official Records of the General Assembly, Sixty-third Session, Supplement No. 6* (A/63/6/Rev.1), programme 7.

biennial programme plan, modified as appropriate, will be submitted to the Committee for Programme and Coordination at its fiftieth session. Its recommendations thereon will be transmitted to the General Assembly at its sixty-fifth session, when it will consider the proposed strategic framework for the period 2012-2013.

Documentation

Report of the Secretary-General on programme implementation and progress of work in the field of population, 2009 (E/CN.9/2010/6)

Note by the Secretary-General on the proposed strategic framework for the period 2012-2013, subprogramme 6, Population, of programme 7, Economic and social affairs (E/CN.9/2010/7)

6. Contribution of population and development issues to the theme of the annual ministerial review in 2010

At its forty-first session,[12] the Commission heard an address by the President of the Economic and Social Council on the various ways in which the Commission might contribute to the new mandates of the Council, in particular the annual ministerial review. In response, the Commission added this item to its annual agenda. At its forty-third session, the Commission will discuss the contributions it could make to the annual ministerial review that the Council will conduct in 2010 on the theme "Implementing the internationally agreed goals and commitments in regard to gender equality and the empowerment of women". The Bureau of the Commission decided to invite the President of the Economic and Social Council to address the Commission under this item in order to launch a discussion on the contribution of population and development issues to the implementation of the internationally agreed goals and commitments in regard to gender equality and the empowerment of women.

7. Provisional agenda for the forty-fourth session of the Commission

In accordance with rule 9 of the rules of procedure of the functional commissions of the Economic and Social Council, the Commission will have before it the draft provisional agenda for its forty-fourth session, together with an indication of the documents to be submitted under each item and the legislative authority for their preparation, in order to enable the Commission to consider those documents from the point of view of their contribution to the work of the Commission and their urgency and relevance in the light of the current situation.

The attention of the Commission is drawn to Council resolutions 1979/41 and 1981/83 on the control and limitation of documentation. In addition, the Commission is reminded that the Council, in paragraph 1 (j) of its resolution 1982/50 on the revitalization of the Council, urged all its subsidiary bodies to exercise the utmost restraint in making requests of the Secretary-General for new reports and studies and to implement fully the provisions of the decisions of the Council and of the General Assembly with respect to the control and limitation of documentation.

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[12] See *Official Records of the Economic and Social Council, 2008, Supplement No. 5* (E/2008/25), chap. V.

The attention of the Commission is also drawn to paragraph 4 of the annex to Council resolution 1982/50, in which the Secretary-General recommended that: (a) the documentation and programme of work of the subsidiary bodies of the Council and the Assembly be streamlined in order to enable the subsidiary bodies to perform effectively the functions entrusted to them; (b) the Council and the Assembly continue to review the provisional agendas for their subsidiary bodies, together with the list of requested documentation, in order, inter alia, to establish greater consistency in the overall request for documentation and its orderly consideration at the intergovernmental level, taking fully into account the medium-term plan and the programme budget; and (c) in doing so, the Council and the Assembly also take into account the need for the consolidation of items and documentation for their subsidiary machinery.

Furthermore, in its resolution 1981/83, the Council instructed its subsidiary bodies to take urgent measures to streamline their agendas and programmes of work and to bring about a substantial reduction in their requests for documents, bearing in mind the duration and the cycles of their meetings, and to report to the Council on measures adopted, taking strictly into account the guidelines set forth in the pertinent resolutions and decisions of the Council and the Assembly.

In decision 1983/163, the Council requested the Secretary-General: (a) to bring to the attention of intergovernmental and expert bodies, before decisions were adopted, any request for documentation that exceeded the ability of the Secretariat to prepare and process on time and within its approved resources; and (b) to draw the attention of intergovernmental bodies to areas where duplication of documentation was likely to occur and/or where opportunities for integrating or consolidating documents that dealt with related or similar themes might exist, with a view to rationalizing documentation.

Documentation

Note by the Secretariat containing the provisional agenda for the forty-fourth session of the Commission (E/CN.9/2010/L.2)

8. Adoption of the report of the Commission on its forty-third session

In accordance with rule 37 of the rules of procedure of the functional commissions of the Economic and Social Council, the Commission shall submit a report to the Council on the work of each session.

Annex

Membership of the Commission on Population and Development at its forty-third session (2010)

(47 members; four-year term)

	Term expires at close of session in the year
Bangladesh	2013
Belarus	2013
Belgium	2013
Benin	2011
Brazil	2013
China	2010
Colombia	2012
Côte d'Ivoire	2013
Croatia	2012
Cuba	2013
Democratic Republic of the Congo	2013
Equatorial Guinea	2011
Finland	2012
Gambia	2010
Germany	2013
Grenada	2011
Haiti	2013
Honduras	2011
India	2010
Indonesia	2013
Iran (Islamic Republic of)	2011
Israel	2013
Jamaica	2010
Japan	2012
Kazakhstan	2012
Kenya	2012
Lebanon	2010

	Term expires at close of session in the year
Mexico	2010
Netherlands	2012
Oman	2010
Pakistan	2013
Poland	2011
Russian Federation	2010
Rwanda	2013
Sierra Leone	2010
South Africa	2010
Spain	2011
Sri Lanka	2011
Sweden	2010
Switzerland	2013
Tunisia	2012
Uganda	2012
Ukraine	2010
United Kingdom of Great Britain and Northern Ireland	2010
United States of America	2010
Uruguay	2010
Zambia	2010

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12-16 April 2010
Item 2 of the provisional agenda*
Adoption of the agenda and other organizational matters

Report on the meetings of the Bureau of the Commission on Population and Development

I. Introduction

1. At its thirtieth session, in 1997, the Commission on Population and Development authorized its Bureau to hold intersessional meetings in preparation for its sessions (see E/1997/25, para. 52). In 2006, in resolution 2006/1, on its methods of work, the Commission requested the Bureau to meet as frequently as necessary in preparation for the annual sessions of the Commission. The Commission also stressed the importance of making written reports on the intersessional meetings of the Bureau (decision 2005/2, para. (j)). In accordance with resolution 2006/1, the Bureau held three meetings between October 2009 and January 2010 and may convene others before the forty-third session of the Commission resumes in April 2010. The three meetings were held at Headquarters, in New York, on 28 October and 9 December 2009 and at the Ministry of Foreign Affairs of Israel, in Jerusalem, from 11 to 13 January 2010.

2. The first meeting of the Bureau, on 28 October 2009, was attended by Daniel Carmon (Chair), Agnieszka Klausa, Shoji Miyagawa, Lizwi Eric Nkombela and Eduardo Rios-Neto (by means of video link). Present at the second meeting, on 9 December 2009, were Mr. Carmon, Ms. Klausa, Mr. Miyagawa, Mr. Nkombela and Mr. Rios-Neto (by means of video link). The third meeting, held from 11 to 13 January, was attended by Mr. Carmon, Ms. Klausa, Mr. Miyagawa and Mr. Rios-Neto. Also present at the third meeting was Zane Dangor, Chief Operations Officer of the Department of Social Development of the Republic of South Africa, participating as an observer. The Director of the Population Division of the Department of Economic and Social Affairs, other staff of the Division and a representative of the United Nations Population Fund (UNFPA) were present at all meetings of the Bureau.

* E/CN.9/2010/1.

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3. The present report summarizes the discussions of the Bureau at those meetings as well as the conclusions reached and the recommendations made.

II. Summary of the deliberations of the Bureau

A. Organization of work for the forty-third session of the Commission

4. The Bureau reviewed the organization of work for the forty-third session and had no comment on it.

B. Keynote speakers

5. At its thirty-eighth session, in its decision 2005/2, the Commission welcomed the format of inviting keynote speakers to the sessions of the Commission and requested the Bureau to make the necessary arrangements for their participation and to inform member States accordingly. In accordance with that decision, the Bureau, after discussing the issue, decided that three keynote speakers would be invited to address the Commission on the special theme "Health, morbidity, mortality and development" and that each speaker would be allotted an hour in which to make a presentation and engage in an interactive dialogue with members of the Commission. The Bureau selected Edward Bos, Carissa Etienne and Barry Popkin as keynote speakers. Mr. Bos, Lead Population Specialist of the World Bank, would be invited to speak on "Population trends, health outcomes and development". Ms. Etienne, Assistant Director-General for Health Systems and Services of the World Health Organization, would be asked to speak on "Strengthening health systems to address current and future challenges in public health". Mr. Popkin, Carla Smith Chamblee Distinguished Professor of Global Nutrition of the University of North Carolina at Chapel Hill, would speak on "Global economic and health change: problems and solutions". As has become customary, the Bureau recommended that the working group be adjourned during the presentations made by keynote speakers.

C. Participation of relevant United Nations entities in the Commission on Population and Development

6. The Bureau noted that the topic of the forty-third session was relevant for a number of United Nations entities, including the Food and Agriculture Organization of the United Nations, the International Labour Organization, the United Nations Development Programme, the United Nations Educational, Scientific and Cultural Organization, the United Nations Children's Fund, the United Nations Development Fund for Women, the United Nations University, the United Nations Environment Programme and the World Health Organization. Thus, the Bureau requested the Chair of the Commission to encourage relevant agencies, funds and programmes of the United Nations system to participate in the Commission's session and to invite them to consider organizing side events during the session. As it had with regard to other sessions of the Commission, the Bureau welcomed the involvement of UNFPA in organizing a side event for the forty-third session.

D. Communication of the Chair with other members of the Commission

7. The Bureau requested its Chair to write to all other members of the Commission underscoring the need to include technical representatives, namely, specialists in the areas of population, public health and policy, in their delegations for the forty-third session. The letter would also provide guidance to members of the Commission regarding the items under which statements could be made, and would outline the relevance of the various items on the provisional agenda for the forty-third session. Information about how to gain access to preliminary versions of the documents for the session would be included. In addition, the letter would outline the proposals made by the Bureau to ensure that the Commission could make a substantive contribution to the 2010 annual ministerial review to be conducted by the Economic and Social Council, whose theme would be "Implementing the internationally agreed goals and commitments in regard to gender equality and empowerment of women".

E. Contributions of the Commission to the review of progress made towards the achievement of the Millennium Development Goals

8. The members of the Bureau noted that the Commission was in a very good position to make a contribution to the process under way aimed at the review of progress made in the achievement of the Millennium Development Goals and to suggest ways in which to accelerate that progress on the basis of the thorough review that the Commission had conducted during its forty-second session, whose theme had been "The contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals". In particular, resolution 2009/1, adopted by consensus at the forty-second session, provided useful guidance on the way ahead, and the documents submitted to the Commission provided the substantive basis on which to act.

9. The Bureau then considered how best to ensure that the outcome of the forty-second session of the Commission would be reflected in the processes leading to the high-level plenary meeting to be held by the General Assembly in September 2010, as well as in the meeting itself and its outcome. The Bureau recognized that it had the responsibility to raise awareness among key stakeholders about the provisions of resolution 2009/1 and about the substantive basis for the recommendations set out in it and their relevance to the achievement of the Millennium Development Goals. To that end, the Bureau requested the Chair to send a letter to the President of the General Assembly summarizing the key recommendations made by the Commission and requesting that the letter be circulated as an official document to all Member States. In addition, the Bureau suggested that the Chair meet with the President of the General Assembly to discuss the various ways in which the Commission might support the process leading to the high-level plenary meeting and that the Chair meet with the Secretary-General to brief him on the relevance of the implementation of the Programme of Action of the Conference to the achievement of the Millennium Development Goals, in particular those related to the empowerment of women, and to the reduction of maternal and child mortality. The Bureau also saw merit in trying to engage the media.

10. Members of the Bureau decided to take the responsibility for raising awareness among their respective regional groups about the relevance of the Programme of Action to the achievement of the Millennium Development Goals and to work to ensure that the importance of the Programme of Action would be acknowledged by those taking part in the round tables on "Addressing the challenge of poverty, hunger and gender equality", and on "Meeting the goals of health and education", which were planned as part of the high-level plenary meeting.

11. In order to ensure continuity in the process of raising awareness about the contributions of the Commission's work to the Millennium Development Goal process, the Bureau suggested that the next Bureau of the Commission (i.e., that elected for the forty-fourth session) meet with it within a month after the closing of the session so that the new Bureau could be briefed about the initiatives being pursued by the current Bureau.

F. The commemoration of the International Conference on Population and Development

12. The Bureau noted that, on 12 October 2009, during the commemoration by the General Assembly of the fifteenth anniversary of the International Conference on Population and Development, the Chair of the Commission had presented a statement highlighting the role that had been played by the Commission as the preparatory body for the 1994 Conference and underscoring the Commission's role as the intergovernmental body entrusted with reviewing and assessing the implementation of the Programme of Action of the Conference.

13. The Bureau remarked that in 2014, the 20-year period established for the achievement of the full implementation of the Programme of Action adopted at the Conference would come to a close. Members of the Bureau observed that there had been many changes in population trends and prospects since 1994 and that, in view of the new development challenges facing the international community, it might be advisable to conduct a major review of the implementation of the Programme of Action in the coming years and to launch a process whereby it could be updated or replaced. They acknowledged that such a decision would have to take into account the outcome of the 2010 high-level plenary meeting on the Millennium Development Goals and the expectation that the Goals would be achieved by 2015. In view of those considerations, the Bureau recommended that the Commission include in the agenda of its forty-fourth session a new item for general debate, namely, the future of the Programme of Action of the International Conference on Population and Development.

G. Relationship of the Commission on Population and Development with the Economic and Social Council

14. The Bureau noted that the Chairs of both the forty-second and the forty-third sessions of the Commission supported the initiative of the Population Division to organize a round-table breakfast in support of the annual ministerial review conducted by the Economic and Social Council. The round-table breakfast was held in Geneva on 8 July 2009 and focused on "The implications of population ageing for global public health". The breakfast was co-chaired by the representatives of

Mexico and Israel. The event was well attended and helped to highlight the relevance of the work of the Commission to the promotion of global public health.

15. The Bureau then discussed some of the possible contributions that the Commission could make to the annual ministerial review, which in 2010 would focus on "Implementing the internationally agreed goals and commitments in regard to gender equality and empowerment of women". The Programme of Action was a key document guiding action to achieve gender equality and empowerment of women, which topics figured prominently in all deliberations of the Commission. Consequently, there was merit in increasing the synergies between the Commission's work and the annual ministerial review. To that end, the Bureau suggested inviting the Permanent Representatives of those Member States planning to make national presentations at the annual ministerial review to join the Commission during the general debate on the contribution of population and development issues to the theme of the annual ministerial review in 2010 (item 6 of the provisional agenda for the forty-third session) so that they could engage in an interactive dialogue highlighting the relevance of the Programme of Action to the empowerment of women.

16. In addition, the Bureau suggested that the Population Division prepare country-specific fact sheets for those Member States making national presentations at the annual ministerial review, in order to assist them in the preparation of those presentations. The fact sheets would focus on areas covered by the Programme of Action and would be sent to the Permanent Representatives of the relevant Member States by the Chair of the Commission with an accompanying letter.

17. The Bureau next focused on the relevance of the Development Cooperation Forum to the Commission on Population and Development, noting that, at its forty-second session, the Commission had taken note of the revised estimates of the funding needed to implement the costed portion of the Programme of Action, which had been submitted to the Commission in document E/CN.9/2009/5. Making Member States aware of those revised cost estimates was considered important. The Bureau therefore requested that the Chair of the Commission deliver a statement on that issue to the Development Cooperation Forum.

18. The Bureau was informed about the meeting to be convened in New York on 29 January 2010 between the Bureau of the Economic and Social Council and the Chairs of the functional commissions in order to discuss the various ways in which the commissions might contribute to the annual ministerial review and the Development Cooperation Forum. The Chair said that he would inform the Bureau of the Council about the proposals made by the Bureau of the Commission regarding the review and the Forum.

H. Special themes for future sessions of the Commission

19. The Bureau recalled the Commission's decision 2009/101, in which it decided that the special theme for its forty-fourth session, in 2011, would be "Fertility, reproductive health and development". The Bureau noted the need to establish a multi-year work programme for the Commission and discussed various themes that might be considered in 2012 and beyond. In doing so, the Bureau took into account the calendar of events and activities planned by other relevant bodies of the United Nations, especially the General Assembly and the Economic and Social Council.

The Bureau also considered the themes that the Commission had addressed in the past. The Bureau noted that in 2013, the General Assembly would hold a second high-level dialogue on international migration and development and concluded that focusing on that issue in 2012 would make a valuable and timely contribution to the preparations for that event. The Bureau therefore recommended that the theme for the Commission's forty-fifth session, in 2012, be "International migration and development".

20. The Bureau also considered how the Commission could prepare for a major review, in 2014, of the implementation of the Programme of Action. After considering several options, the Bureau recommended that the forty-sixth session, in 2013, focus on "The role of national action, international cooperation and partnerships in the implementation of the Programme of Action of the International Conference on Population and Development". The consideration of that theme would ensure that a key part of the Programme of Action essential for its implementation would be addressed in preparation for a major review and assessment of the achievement of the goals and objectives of the Programme of Action. Although the Bureau acknowledged that the Commission had thus far selected themes only two years in advance, it considered that establishing a longer work programme would make it easier for the Commission to discuss, in 2011, plans for the commemoration of the twentieth anniversary of the Conference and the future of the Programme of Action.

I. Resolutions and decisions

21. The Bureau recommended that the Commission consider adopting the following resolutions or decisions: (a) a decision on the provisional agenda for the forty-fourth session; (b) a decision on the themes for its forty-fifth and forty-sixth sessions, in 2012 and 2013, respectively; and (c) a resolution on the special theme of the forty-third session, namely, "Health, morbidity, mortality and development".

22. As for previous sessions, the Bureau recommended that a working group be established at the start of the resumed forty-third session of the Commission to discuss issues that might result in resolutions or decisions. The working group should begin its work on the afternoon of the first day of the resumed session of the Commission. The Bureau also recommended that the Chair of the Commission distribute initial drafts of resolutions and decisions to facilitate the deliberations of the working group. The Bureau further requested that the Chair's drafts be made available to other members of the Commission and the regional groups three weeks prior to the resumption of the forty-third session of the Commission.

J. Briefing for members of the Commission

23. The Bureau recommended that the Director of the Population Division organize, approximately one month prior to the resumption of the forty-third session, a briefing for delegations on the status of the documentation for the session, the organization of work and the resolutions and decisions likely to be considered by the Commission.

24. The Bureau stressed the importance of the timely availability of documents for the forty-third session in facilitating the preparation of statements by delegations.

The Bureau endorsed the posting on the Internet of unedited advance versions of those documents in English.

III. Conclusions and recommendations

25. **The Bureau recommended the adoption of the draft organization of work for the forty-third session of the Commission.**

26. **The Bureau decided that three keynote speakers would be invited to address the Commission on the special theme "Health, morbidity, mortality and development".**

27. **The Bureau recommended that the special theme for 2012 be "International migration and development" and that the special theme for 2013 be "The role of national action, international cooperation and partnerships in the implementation of the Programme of Action of the International Conference on Population and Development".**

28. **The Bureau recommended that a working group be established at the start of the resumed forty-third session of the Commission to discuss issues that might result in resolutions or decisions. The working group should begin its work on the afternoon of the first day of the resumed session of the Commission.**

29. **The Bureau recommended that the Commission consider adopting the following: (a) a decision on the provisional agenda for the forty-fourth session; (b) a decision on the themes for the forty-fifth session, in 2012, and the forty-sixth session, in 2013; and (c) a resolution on the special theme of the forty-third session, namely, "Health, morbidity, mortality and development".**

30. **The Bureau recommended that the Commission include in the provisional agenda for its forty-fourth session a new item for general debate, namely, the future of the Programme of Action of the Conference.**

31. **The Bureau requested that the Chair of the Commission distribute initial drafts of resolutions and decisions that might facilitate the deliberations of the working group. The Bureau requested that the Chair's drafts be made available to other members of the Commission and to the regional groups three weeks prior to the resumption of the forty-third session of the Commission.**

32. **The Bureau recommended that the Director of the Population Division organize, one month prior to the resumption of the forty-third session of the Commission, a briefing for delegations on the status of the documentation for the session, the organization of work and the resolutions and decisions likely to be considered by the Commission.**

33. **The Bureau decided to invite the President of the Economic and Social Council to address the Commission under item 6 of the provisional agenda for the forty-third session and to invite the Permanent Representatives of those Member States making national presentations at the annual ministerial review to be held in 2010 to participate in an interactive dialogue on the relevance of the Programme of Action to achieving gender equality and the empowerment of women, which would be held under the same item.**

34. **The Bureau suggested that the Chair of the Commission make a statement at the Development Cooperation Forum to be conducted by the Economic and Social Council in 2010, in order to raise awareness about the revised cost estimates related to the implementation of the costed portion of the Programme of Action.**

35. **The Bureau decided that the Chair of the Commission would send to the President of the General Assembly a letter highlighting the relevance of the Programme of Action to the achievement of the Millennium Development Goals and request that it be distributed as an official document to Member States.**

36. **The Bureau suggested that the Chair meet with the President of the General Assembly to discuss the various ways in which the Commission might support the process leading to the 2010 high-level plenary meeting, as well as with the Secretary-General to brief him on the relevance of the implementation of the Programme of Action to the achievement of the Millennium Development Goals, in particular those related to the empowerment of women, the reduction of child and maternal mortality and the control of the HIV/AIDS epidemic.**

37. **In order to ensure continuity in the process of raising awareness about the contributions of the Commission's work to the Millennium Development Goal process, the Bureau suggested that the next Bureau of the Commission (i.e., that elected for the forty-fourth session) meet with it within a month after the closing of the session so that the new Bureau might be briefed about the initiatives being pursued by the current Bureau.**

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Actions in follow-up to the recommendations of the International Conference on Population and Development

Health, morbidity, mortality and development

Report of the Secretary-General

Summary

The present report has been prepared in response to Commission on Population and Development decision 2008/101, in which the Commission decided to consider in 2010 the theme of health, morbidity, mortality and development. The report documents the major reductions in mortality achieved since 1950 in all countries and the shifting burden of disease from communicable to non-communicable diseases. It reviews the interrelations between health and development, noting that there is a persistent association between increasing incomes and better health but that, at the country level, health improvements have also occurred without major changes in income. Such achievements can be repeated by combining an intersectoral approach to disease prevention with measures to strengthen health-care delivery in a sustainable manner, particularly by ensuring that health systems have comprehensive primary health care at their core.

* E/CN.9/2010/1.

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Contents

		Page
I.	Introduction	3
II.	Mortality trends	4
III.	Causes of death	10
IV.	The burden of disease	13
V.	Health and development	16
VI.	The role of primary health care	18
VII.	The need for health workers	20
VIII.	Prevention and treatment of communicable diseases and maternal conditions	22
IX.	Prevention of non-communicable diseases	25
X.	Preventing injuries	28
XI.	Conclusions and recommendations	29

I. Introduction

1. The unprecedented decrease in mortality that began to accelerate in the more developed parts of the world in the nineteenth century and expanded to all the world in the twentieth century is one of the major achievements of humanity. By one estimate, life expectancy at birth increased from 30 to 67 years between 1800 and 2005, leading to a rapid growth of the population: from 1 billion in 1810 to nearly 7 billion in 2010.

2. Over the past two centuries, decreasing mortality has generally been accompanied by rising incomes but there is agreement that advances in technology and in the understanding of the causes of disease are responsible for the major share of that decline. Thus, higher calorie intake made possible by rising agricultural productivity, better hygiene facilitated by improvements in sanitation and access to safe drinking water, the development of insecticides, and the many breakthroughs in medical technology leading to cost-effective public health interventions and effective treatments have all contributed to reduce the incidence of disease at younger ages and prevent death when disease strikes.

3. A major change in the causes of death underlies the decline in mortality. Low life expectancies are typical of populations where the majority of deaths are due to communicable diseases and mortality in childhood is high. Marked increases in longevity have resulted from controlling the spread of communicable diseases and using effective medicinal drugs to treat them. An epidemiological transition has thus occurred whereby the causes of death have passed from being preponderantly communicable diseases to being dominated by non-communicable diseases. Concomitantly, the distribution of deaths by age has shifted to older ages and life expectancy has reached unprecedentedly high levels.

4. In the 1970s, when it became clear that the major infectious and parasitic diseases that had affected humanity for centuries were being successfully controlled or treated, thus reducing mortality even in the absence of sustained economic growth, the expectation was that mortality from communicable diseases would continue to decline everywhere. The advent of the human immunodeficiency virus (HIV) dashed those hopes and introduced an era where increases in mortality due to communicable disease became a reality in many low-income countries. In addition, infectious agents have been found to be the root cause of diseases that are considered non-communicable, such as cancers of the cervix, liver or stomach, and the emergence of new infectious agents, such as severe acute respiratory syndrome (SARS), or the mutations of the influenza virus pose the threat of a world pandemic. Consequently, there are growing concerns that the decline in mortality may not continue in the future.

5. This report documents past trends in mortality, the changing causes of death and the burden of disease. It reviews our current understanding of the interrelations between health and development, and discusses the main health challenges facing countries at different stages of development. Improving health and reducing mortality is a major objective of development, as the Millennium Development Goals make plain. But, as this report will show, the health-related Millennium Development Goals focus on the causes of a small share of deaths worldwide and are relevant mainly for low-income countries. Major efforts are already under way to achieve the Goals and in 2009 the Commission on Population and Development

focused its deliberations on their attainment.[1] For that reason, this report focuses mainly on health issues beyond the Millennium Development Goals and on measures to ensure that health improvements are achieved on all fronts.

II. Mortality trends[2]

6. Globally, life expectancy increased rapidly after 1950, rising from 47 years in 1950-1955 to 68 years in 2005-2010. The largest gains were made by developing countries, whose average life expectancy rose from 41 to 66 years, but life expectancy increased in every region. As a result, gaps in life expectancy between major areas and among income groups narrowed. Nevertheless major differences persist. Today's high-income countries[3] have higher life expectancies than the middle-income countries and life expectancy is lowest in low-income countries (figure I). Geographically, northern America and Europe have experienced the highest life expectancies and recorded the lowest increases since 1950, partly because they started from a high base. In addition, rising mortality in Eastern Europe, particularly in the Russian Federation, during the early 1980s and after 1990 dampened the rise in European life expectancy.

7. In the developing world, Asia recorded the highest gains in life expectancy since 1950, with China and India achieving major increases: from 41 and 38 years, respectively, in 1950-1955 to 72 and 68 years in 2005-2010. Life expectancy also rose considerably in Latin America and the Caribbean — from 51 to 73 years — especially after starting from a moderate level. Africa, however, had made only moderate progress by 1980 and, because of the HIV/AIDS epidemic, has not yet managed to lift its average life expectancy above 55 years. Because the low-income countries include India, recent improvements in life expectancy in that group have surpassed those in Africa and their average life expectancy has reached 60 years.

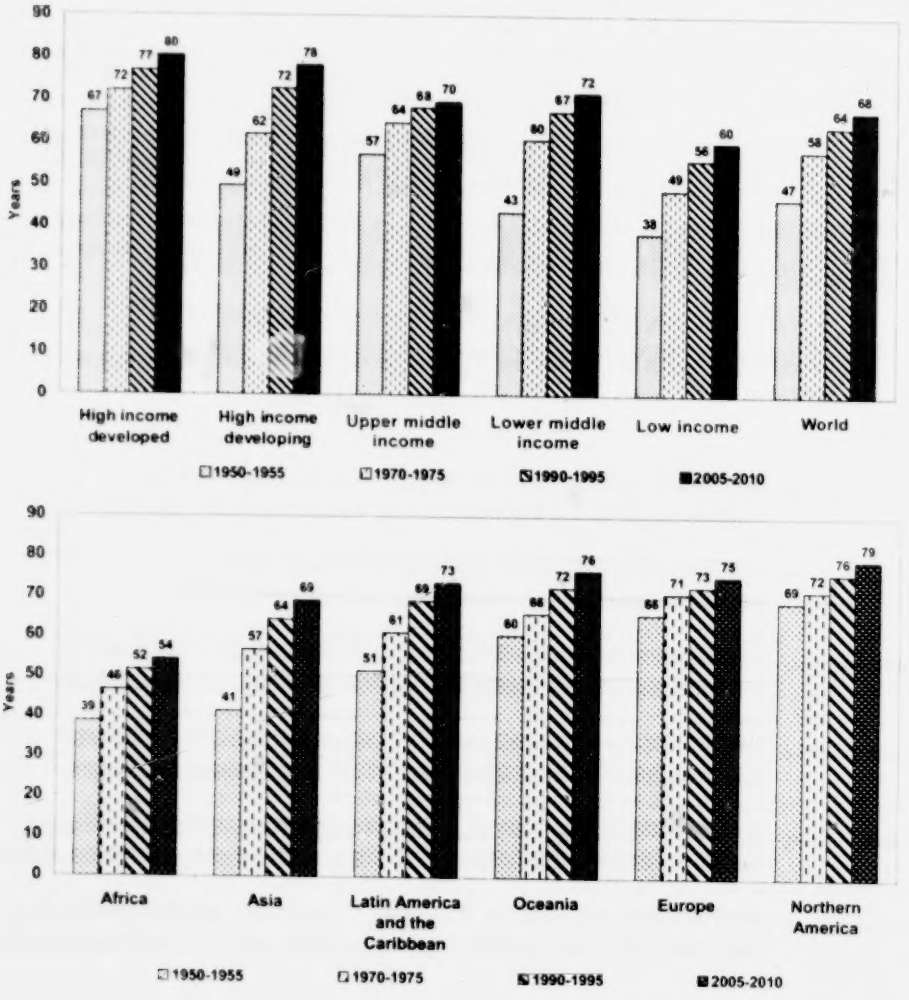
[1] See the report of the Secretary-General on world population monitoring, focusing on the contribution of the Programme of Action of the International Conference on Population and Development to the internationally agreed development goals, including the Millennium Development Goals (E/CN.9/2009/3).

[2] All estimates cited in this section are from *World Population Prospects: The 2008 Revision* (United Nations publication, Sales No. 09.XII.6).

[3] The list of countries by income group can be found in *The Global Burden of Disease: 2004 Update* (World Health Organization, 2008).

Figure I

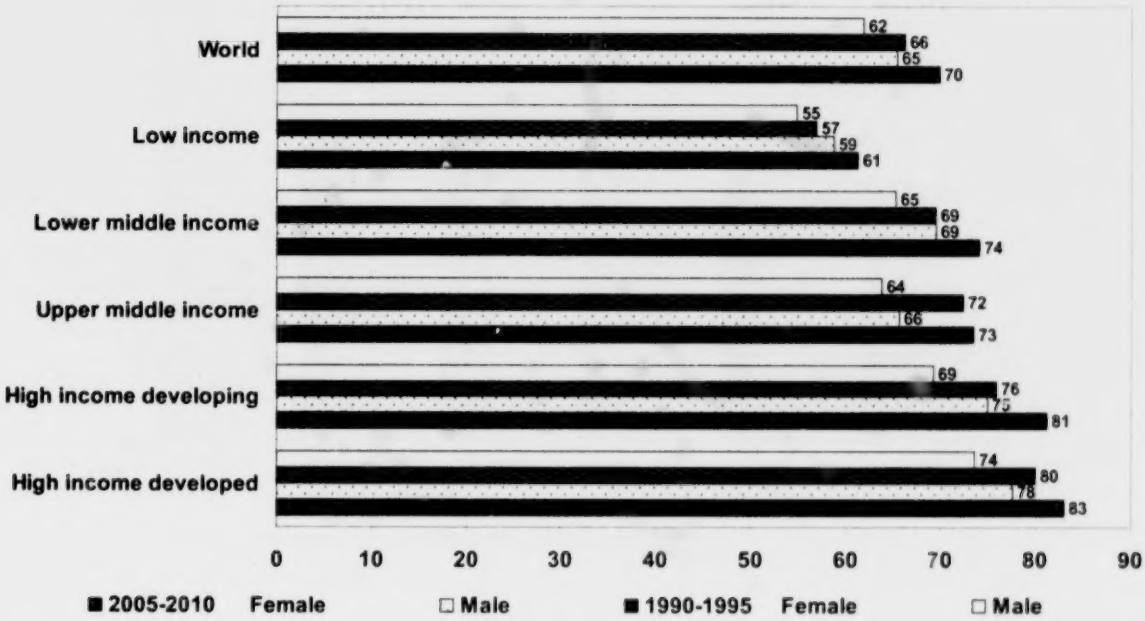
Evolution of life expectancy at birth by income group and major area, 1950-1955 to 2005-2010



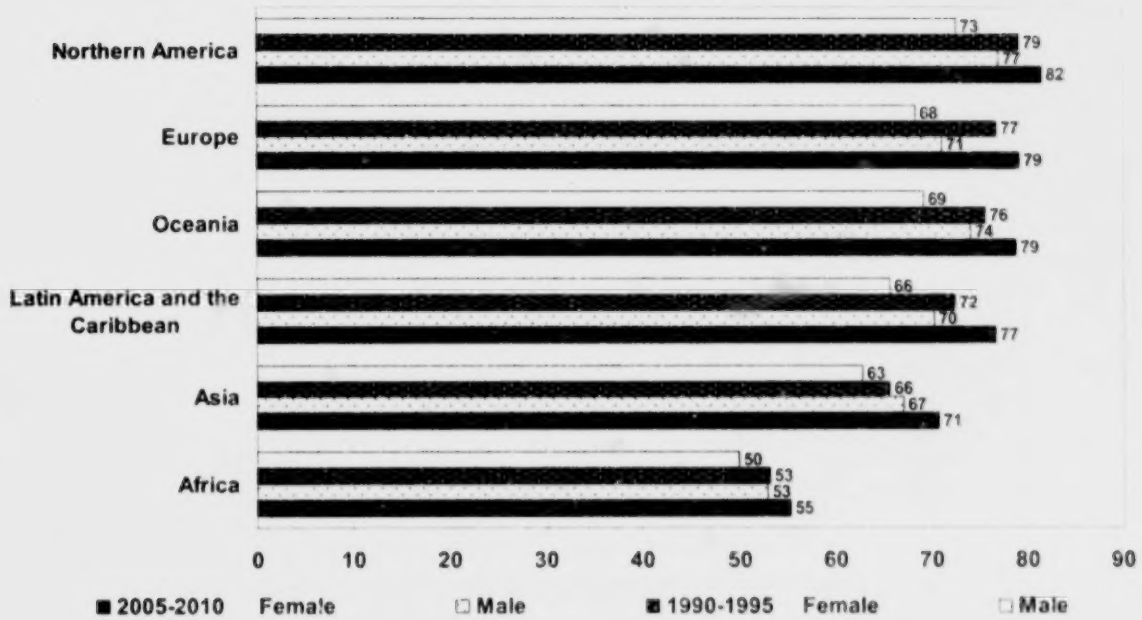
8. In all regions and income groups female life expectancy exceeds male life expectancy (figure II). Globally, females have a life expectancy of 70 years in 2005-2010, compared to 65 for males. The female advantage in life expectancy is highest in Europe and in Latin America and the Caribbean. In Europe, the large female advantage owes much to the markedly higher survivorship of females than males in Eastern Europe, particularly in the Russian Federation, where, at current mortality rates, females expect to live 13 years longer than males (73 v. 60 years). In Latin America and the Caribbean the female advantage amounts to 7 years of life expectancy. The female advantage is lowest in Africa, amounting to scarcely 2 years, partly as a result of the high prevalence of HIV/AIDS among African women and high levels of maternal mortality in the region. In all regions, except Asia, the female advantage has declined since 1990-1995. In developed countries that trend is associated with reduced sex differences in mortality due to cardiovascular disease and injuries.[4]

Figure II

Life expectancy at birth by sex for income and geographical groups, 1990-1995 and 2005-2010

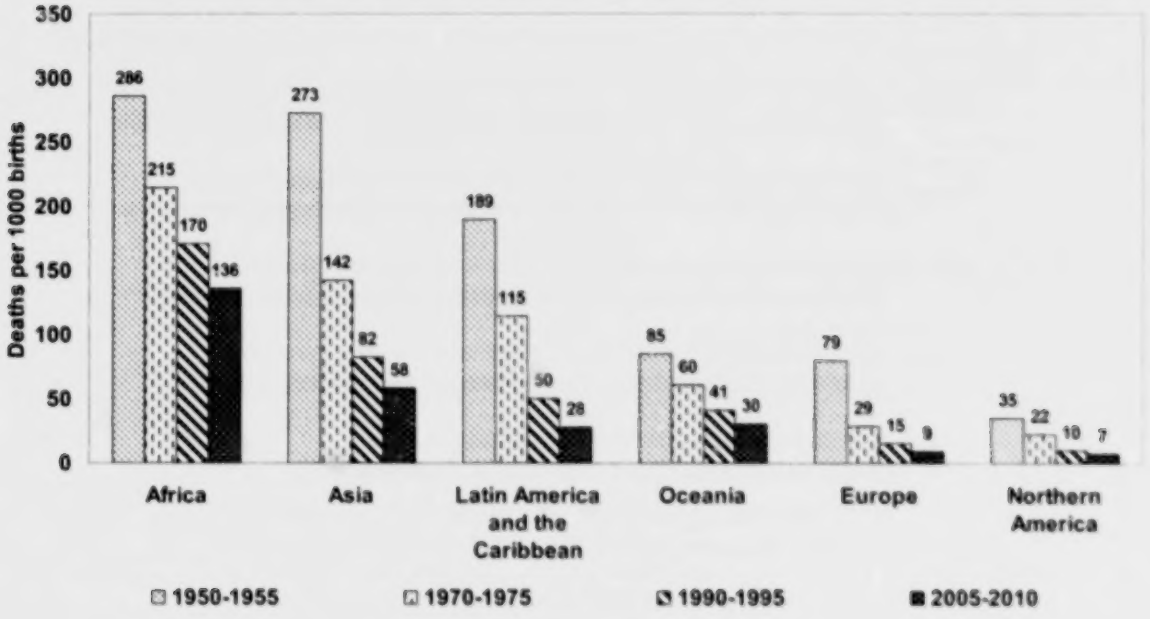


[4] Frank Trovato and Nils B. Heyen, "A varied pattern of change of the sex differential in survival in the G7 countries", *Journal of Biosocial Science*, vol. 38 (2006), pp. 391-401.



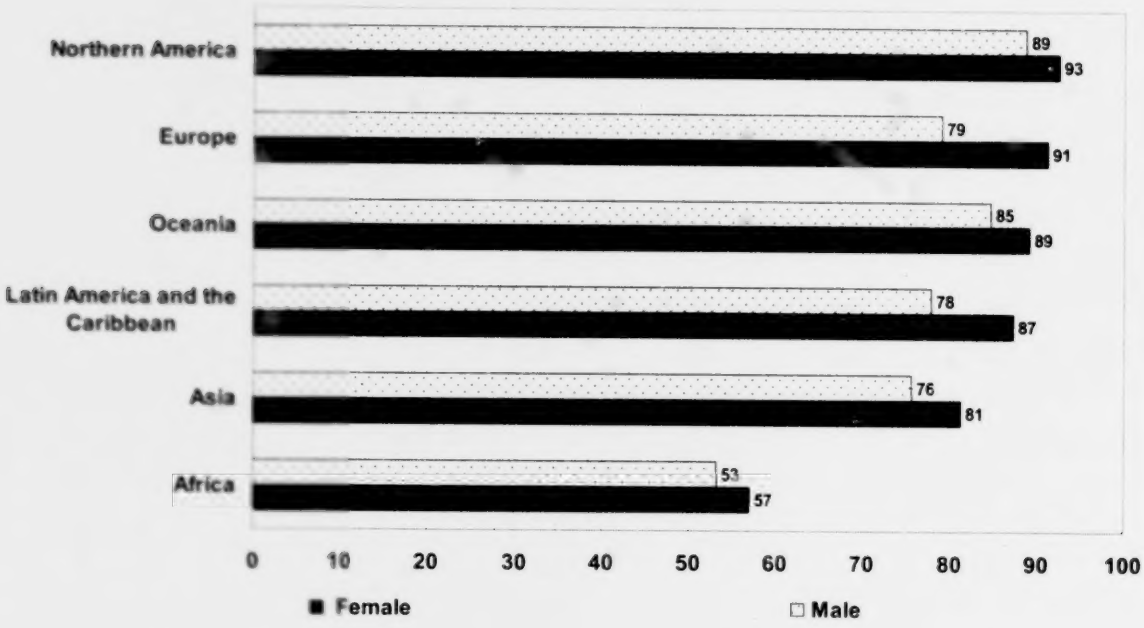
9. A major contributor to the increase in life expectancy has been the decline of mortality in childhood. Globally, mortality under age 5 declined from 233 deaths per 1,000 births in 1950-1955 to 71 deaths per 1,000 in 2005-2010, a 70 per cent reduction. Most of that reduction occurred in developing countries, whose under-5 mortality dropped from 271 to 78 deaths per 1,000 between 1950-1955 and 2005-2010. Although all regions have experienced major reductions in child mortality, marked differences persist (figure III). Today, under-5 mortality is below 10 deaths per 1,000 in Europe and Northern America but still a high 136 deaths per 1,000 in Africa. Millennium Development Goal 4 calls for a two-thirds reduction in child mortality between 1990 and 2015. Such a reduction is particularly hard to achieve when child mortality is already low. Yet Europe and Latin America and the Caribbean have made greater progress toward that goal than other regions. Declines have been particularly slow in Africa where 4.7 million children under 5 die each year, mainly from preventable causes.

Figure III
Under-5 mortality by major area, 1950-1955 to 2005-2010



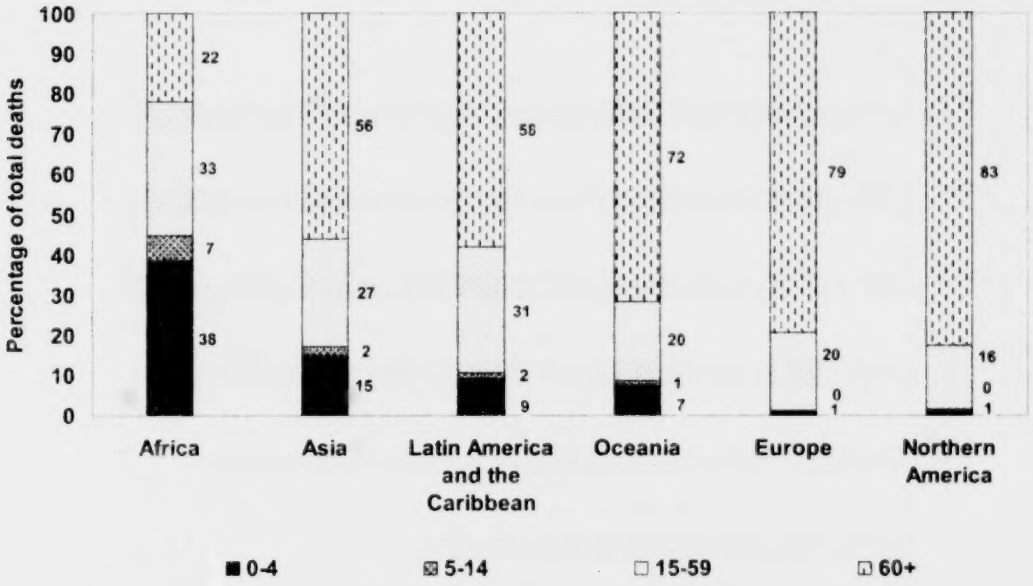
10. Because of progress made in reducing mortality at younger ages, the probability of surviving to age 60 at current mortality rates is high, amounting to 79 per cent for females and 73 per cent for males at the global level. As with other indicators of mortality, marked differences exist among major areas and between the sexes (figure IV). At current mortality rates, females have the highest probability of survival to age 60 in every region, with particularly high probabilities prevailing in Europe and Northern America (more than 90 per cent). Female chances of surviving to age 60 are also high in Latin America and the Caribbean and Oceania (87 per cent and 89 per cent, respectively). In Asia, they are slightly lower, at 81 per cent, but they are lowest in Africa (57 per cent). Male chances of surviving to age 60 are highest in Northern America and Oceania, at 89 per cent and 85 per cent, respectively; they are lower in Asia, Europe and Latin America and the Caribbean (ranging from 76 per cent to 79 per cent), and particularly low in Africa (53 per cent). That is, even in areas where female mortality is high during the reproductive years, female chances of survival to age 60 are higher than those of males.

Figure IV
Probability of surviving to age 60 according to the mortality rates of 2005-2010 by sex and major area (percentage)



11. As life expectancy rises, deaths become increasingly concentrated at older ages. Thus, at the world level, the proportion of deaths under age 5 declined from 40 per cent in 1950-1955 to 16 per cent in 2005-2010, whereas that of deaths at age 60 or over rose from 26 per cent to 54 per cent between the two periods. Similarly, whereas in Africa today 38 per cent of all deaths occur before age 5, in Europe and Northern America barely 1 per cent do so. Furthermore, in those two major areas, nearly 80 per cent of deaths occur at older ages but in Africa, just 22 per cent of all deaths occur at age 60 or over (figure V).

Figure V
Distribution of deaths by age group and major area, 2005-2010



III. Causes of death[5]

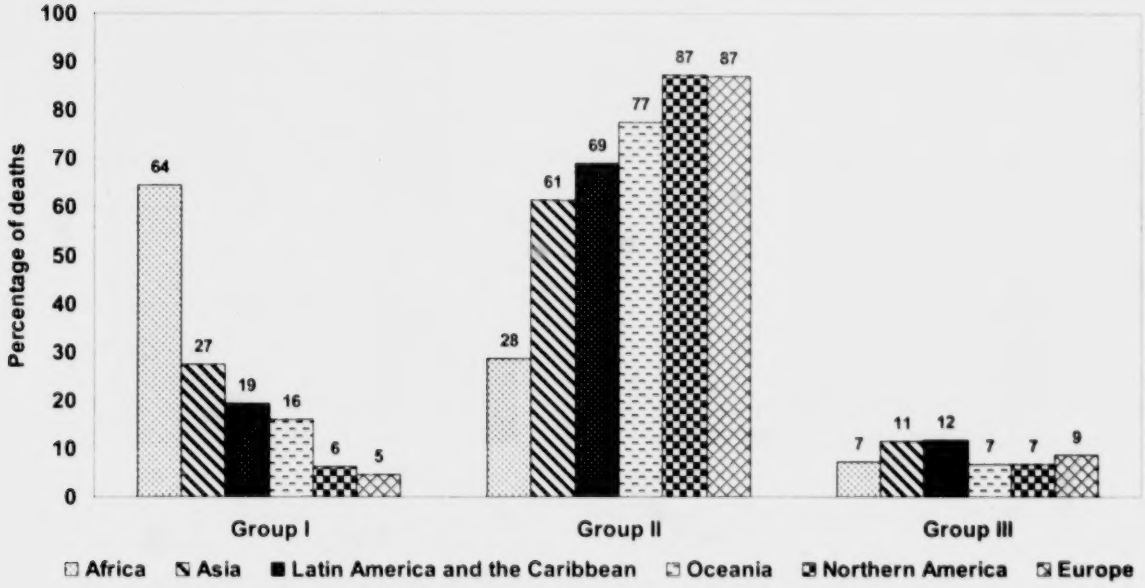
12. The epidemiological transition that underpins the reduction of mortality has produced a major shift in the causes of death. The World Health Organization (WHO) estimates the distribution of deaths by cause according to three major groups of causes. Group I includes infectious and parasitic diseases, respiratory infections, maternal and perinatal conditions, and nutritional deficiencies, that is, it includes all the communicable diseases associated with poverty. Group II encompasses the non-communicable diseases, namely, neoplasms (cancer); cardiovascular, respiratory and digestive diseases; diseases of the genitourinary system; musculoskeletal, skin and oral diseases; diabetes, nutritional and endocrine disorders, neuropsychiatric and sense organ disorders, and congenital abnormalities. Group III includes all injuries, whether intentional or unintentional.

13. In 2004, 31 per cent of all deaths in the world resulted from the causes in Group I, 60 per cent from those in Group II and 10 per cent from injuries (Group III). The distribution of deaths by cause varied considerably among the major areas (figure VI). In Europe and Northern America, at most 6 per cent of all deaths resulted from communicable diseases (Group I), whereas non-communicable diseases (Group II) accounted for 87 per cent of all deaths. Non-communicable diseases also accounted for the majority of deaths in Asia, Latin America and the Caribbean, and Oceania, with proportions ranging from 61 per cent in Asia to 77 per

[5] All estimates cited in this section are derived from data presented in *World Health Statistics 2009* (World Health Organization, 2009).

cent in Oceania. Only in Africa was mortality dominated by communicable diseases: they accounted for 64 per cent of all deaths in the continent.

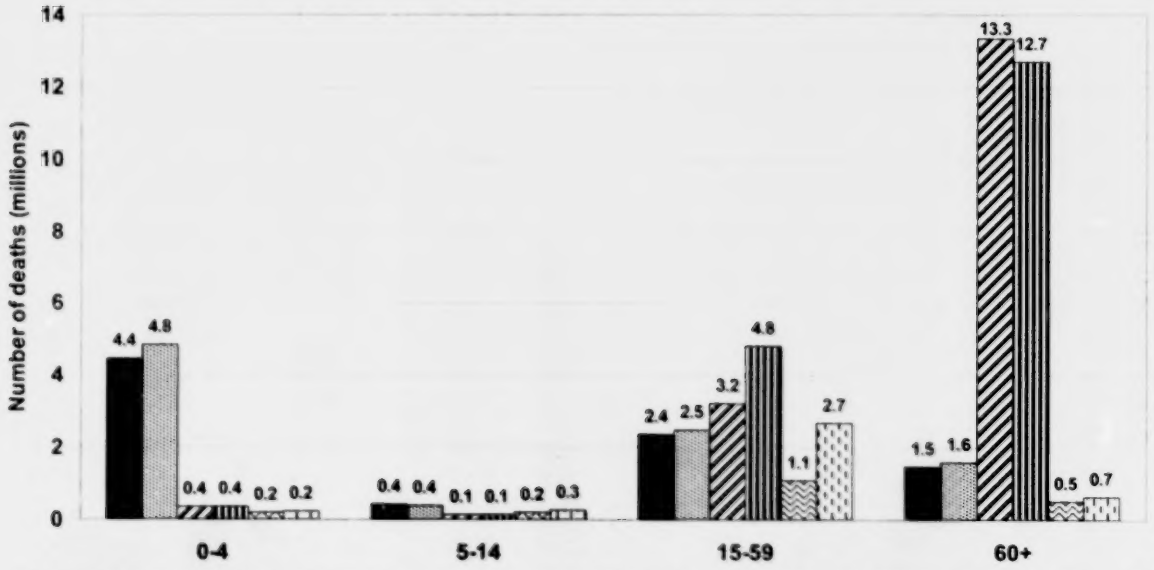
Figure VI
Distribution of deaths by cause and major area, 2004



14. The causes of death differ by age. In 2004, 89 per cent of the deaths among children under age 5 were caused by communicable diseases as were 53 per cent of those among children aged 5 to 14. Injuries accounted for the other major proportion of deaths among children aged 5 to 14, 30 per cent. Among persons aged 15 to 59, non-communicable diseases accounted for the major share of deaths, 48 per cent, with communicable diseases accounting for a further 29 per cent and injuries for 23 per cent. Non-communicable diseases were the cause of the vast majority of deaths among persons aged 60 or over (86 per cent) and just 10 per cent were due to communicable diseases.

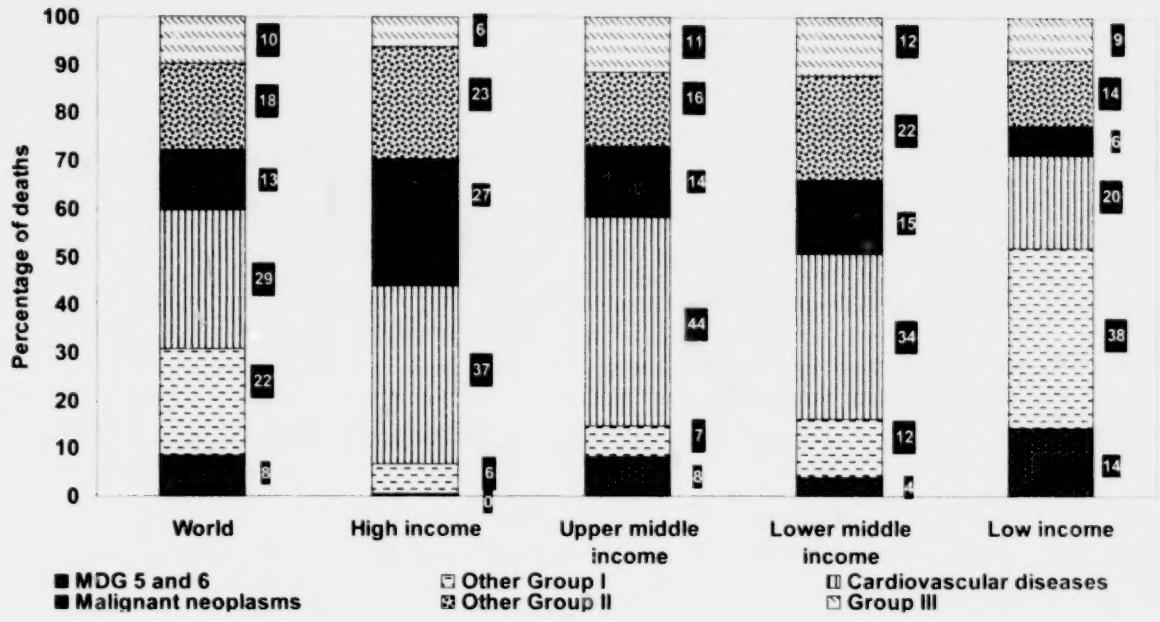
15. Data on the number of deaths by cause, age group and sex indicate that at all ages below 60 and for every group of causes, the number of deaths among males surpassed or equalled that among females (figure VII). That finding holds even for the deaths over ages 15 to 59 due to Group I causes, which include those related to maternal conditions. Only among deaths occurring at age 60 or over does the number of female deaths due to non-communicable diseases surpass that of males, mainly because more women than men survive to old age.

Figure VII
Number of deaths by cause, sex and age group, 2004



16. The distribution of deaths by cause varies significantly among countries grouped by income (figure VIII). In high- and middle-income countries, cardiovascular diseases account for the largest proportion of deaths, ranging from 34 per cent to 44 per cent. Malignant neoplasms constitute the second major cause of death in high-income countries, but in middle-income countries "other Group II" (non-communicable diseases excluding malignant neoplasms and cardiovascular diseases) account for greater shares of all deaths than neoplasms. In addition, injuries cause double the percentage of deaths in middle-income countries (11 per cent to 12 per cent) than in high-income countries (6 per cent). In low-income countries, cardiovascular diseases and malignant neoplasms together account for 26 per cent of all deaths, but their share is markedly lower than the 38 per cent accounted for by "other Group I" (i.e., communicable diseases excluding those covered by Millennium Development Goals 5 and 6). The share of deaths caused by HIV/AIDS, tuberculosis, malaria and maternal conditions (Goals 5 and 6) is highest in low-income countries (14 per cent), followed by upper middle-income countries (8 per cent) and lower middle-income countries (4 per cent). In high-income countries the share of deaths caused by those diseases is virtually nil.

Figure VIII
Percentage of deaths by cause for major income group, 2004



IV. The burden of disease[6]

17. While the causes of death are indicative of the impact of different diseases on a population, they do not properly reflect a population's health status because many diseases are not fatal and yet reduce the quality of life of those suffering from them. For that reason another measure, the disability adjusted life years (DALYs), is used to reflect both the fatal and non-fatal burden of illness and injury on a population. WHO uses the term "disability" to refer to a "loss of health", where health means having full functional capacity in such domains as mobility, cognition, hearing and vision. The DALYs are the sum of the years of life lost due to premature death and the years of healthy life lost because of disability due to disease or injury.

18. In 2004, 1.5 billion DALYs were lost by the 6.4 billion people on Earth (see table). Low-income countries accounted for 54 per cent of all the DALYs, although their share of the population was just 37 per cent. The lower middle-income countries accounted for 30 per cent of the DALYs, a share lower than that of their population (38 per cent). The upper middle-income countries constituted 9 per cent of the world population and accounted for 8 per cent of the DALYs and the high-income countries, which comprised 15 per cent of the population, produced only 8 per cent of the DALYs. Thus, the global burden of disease was disproportionately heavy on the low-income countries.

[6] All estimates cited in this section are derived from data relative to *The Global Burden of Disease: 2004 Update* (World Health Organization, 2008).

19. At the global level, non-communicable diseases accounted for 48 per cent of the DALYs, communicable diseases, maternal and perinatal conditions and nutritional deficiencies for a further 40 per cent and injuries for 12 per cent. The group of neuropsychiatric disorders accounted for the largest share of the global DALYs (13 per cent) and was followed by cardiovascular diseases and injuries other than road traffic accidents (10 per cent each). Sense organ, musculoskeletal and congenital conditions together accounted for 9 per cent of the global DALYs, the same share as that of HIV/AIDS, tuberculosis, malaria and sexually transmitted diseases combined.

20. Non-communicable diseases accounted for the majority of the DALYs in high-income countries (85 per cent) and middle-income countries (62 per cent). Both the neuropsychiatric disorders and cardiovascular diseases were responsible for large shares of the DALYs in high- and middle-income countries. Injuries other than road traffic accidents accounted for a major share of the DALYs in upper middle-income countries, which include the Russian Federation, and in low middle-income countries, which include China.

21. In low-income countries, communicable diseases accounted for the majority of the DALYs (57 per cent) with the share of HIV/AIDS, tuberculosis, malaria and sexually transmitted diseases combined reaching 13 per cent. Nevertheless, non-communicable diseases were responsible for 33 per cent of the burden of disease in those countries and, among them, neuropsychiatric disorders accounted for a high 9 per cent. Injuries other than road traffic accidents accounted for 8 per cent of the DALYs and were followed by sense organ, musculoskeletal and congenital diseases combined and cardiovascular diseases, each with 7 per cent. Maternal conditions accounted for a further 4 per cent of the DALYs in low-income countries, the highest share of maternal conditions among all income groups.

Distribution of disability adjusted life years according to cause for the world and income groups, 2004

	World	*High income countries*	*Upper middle income countries*	*Lower middle income countries*	*Low income countries*
Population (millions)	6 437	977	580	2 465	2 413
Total disability adjusted life years (millions)	1 523	122	121	452	828
			Percentage		
Communicable diseases, maternal and perinatal conditions	39.7	6.0	21.4	22.5	56.6
Non-communicable diseases	48.0	84.8	63.0	61.7	32.9
Injuries	12.3	9.2	15.6	15.8	10.4
Of which:					
Neuropsychiatric disorders	13.1	25.8	16.2	16.6	8.8
Cardiovascular diseases	9.9	14.6	17.7	12.1	6.9
Injuries excluding road traffic accidents	9.6	6.6	12.5	11.9	8.4
Sense organ, musculoskeletal and congenital	9.4	13.2	9.5	12.2	7.3
HIV/AIDS, tuberculosis, malaria and sexually transmitted diseases	9.0	0.8	10.9	3.8	12.8
Neoplasms	5.2	14.9	7.3	7.3	2.4

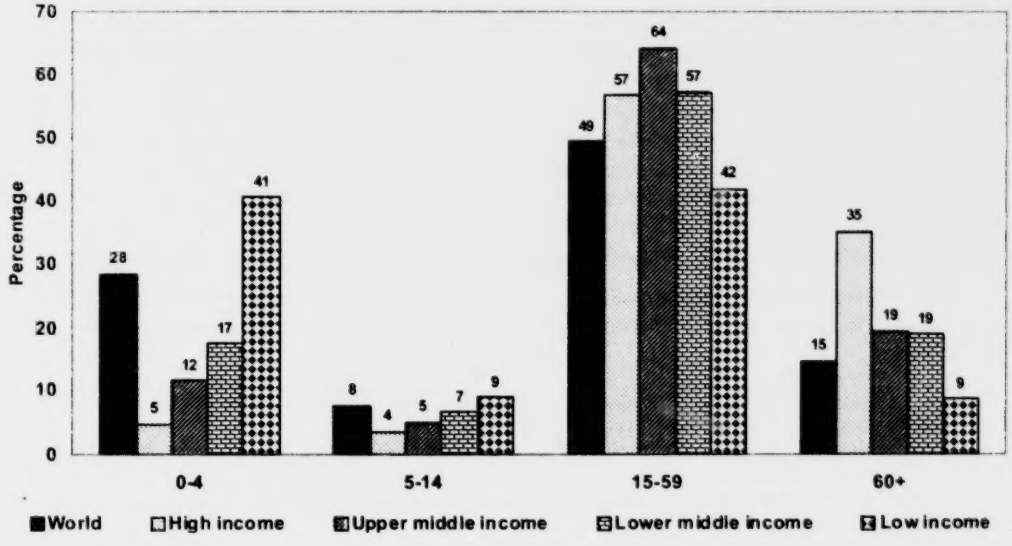
	World	*High income countries*	*Upper middle income countries*	*Lower middle income countries*	*Low income countries*
Road traffic accidents	2.7	2.6	3.1	3.9	2.0
Maternal conditions	2.6	0.5	1.1	1.8	3.5
Diabetes	1.3	3.0	2.1	1.7	0.7
Neglected tropical diseases	1.2	0.0	0.3	0.7	1.9

22. Diabetes accounted for just 1 per cent of the DALYs at the global level but it was responsible for 3 per cent of those of upper-income countries and 2 per cent in the middle-income countries. Neglected tropical diseases, which accounted for 1 per cent of the global DALYs, were responsible for 2 per cent of those of low-income countries and 89 per cent of the burden of disease they caused affected people aged 5 to 59, that is, those of school or working age.

23. At the world level, children under 5 accounted for 28 per cent of the DALYs in 2004, whereas persons aged 15 to 59 accounted for 49 per cent and persons aged 60 or over for 15 per cent (figure IX). In low-income countries, children under 5 and persons aged 15 to 59 accounted for 41 per cent and 42 per cent, respectively, of the DALYs. In all other income groups, persons aged 15 to 59 accounted for the highest proportion of the DALYs, followed by persons aged 60 or over. In high- and middle-income countries, children under 5 accounted for low proportions of the DALYs. Because of the high proportions of older persons in high-income countries, 31 per cent of the DALYs in those countries was attributable to persons aged 60 or over. Clearly, major differences in the burden of disease by age are associated with income levels.

Figure IX

Distribution of disability adjusted life years by age group for the income groups, 2004



V. Health and development

24. Better health is associated with higher incomes and better socio-economic status, but the direction of causality remains contested. When estimates of life expectancy for all countries in the world are plotted against GDP per capita, they show an increasing and concave relationship, meaning that, at lower income levels, life expectancy rises faster with increases in income than it does at high levels of income. The shape of this relationship has remained generally stable over time, but the curve has shifted upward on the life expectancy axis, implying that life expectancy has risen without major increases in income. By one estimate, just between 10 per cent and 25 per cent of the overall increase in life expectancy between the 1930s and the 1960s can be attributed to increases in income, whereas the rest of the increase was due to other factors, including public health interventions and the diffusion of health innovations.[7]

25. The role of health as human capital and therefore as a determinant of economic growth has increasingly been the focus of attention. It is accepted that, starting in 1800, increases in food supply in today's developed countries produced reductions in morbidity and mortality that increased worker productivity and income growth. Economists posit that longer lives generate incentives to invest in education, increase the time in the labour force and reduce sick time, therefore raising productivity and the income-generating potential of a population. Studies at the individual level[8] have corroborated that health status matters in determining cognitive development, labour force participation, wages and earnings, hours worked, savings decisions and the age at retirement.

26. Analysis of panel data reveals that education and economic circumstances in childhood are key predictors of health outcomes later in life but the effect on health of an individual's own financial resources in adulthood is less clear cut. It also shows that unanticipated health shocks produce significant reductions in socio-economic status because they reduce a person's capacity to work and lead to income losses.[9] Thus, health both affects and is affected by socio-economic status.

27. It is not straightforward to generalize the results of studies at the individual level to the national level because of other macro effects related to better health, including positive externalities, such as the effect of health on education, or the diminishing returns triggered by increased population pressure on limited land or physical capital that arise when mortality decreases. Because better health improves cognition and produces incentives to invest in education and education is a driver of economic growth, analyses that incorporate the simultaneous effect of both show that the indirect effect of improvements in health can be significant and positive.

28. Macroeconomic analysis of the relationship between health and economic growth has taken several approaches. The first uses aggregate economic growth

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[7] Samuel Preston, "The changing relation between mortality and level of economic development", *Population Studies*, vol. 29, No. 2 (1975), pp. 231-248.

[8] M. J. Jusain, "Contribution of health to economic development: a survey and overview" (2009); available from www.economics-ejournal.org; and M. Suhrcke and others, *The Contribution of Health to the Economy in the European Union* (European Commission, Health and Consumer Protection Directorate-General, 2005).

[9] J. P. Smith, "Unravelling the SES health connection", IFS Working Papers No. W04/02 (Institute for Fiscal Studies, 2004).

models that incorporate explicitly the effects of health. Such studies suggest that increases in life expectancy can contribute to increasing output, but the effect is stronger if increases in life expectancy are the result of rising life spans among productive workers and weaker if they result from falling infant mortality, which accelerates population growth without necessarily increasing the skill level of the population.[10]

29. The second approach uses regression on cross-sectional data to assess the determinants of increasing income per capita. These studies find a positive, significant and sizable influence of life expectancy on income.[10] Critics of this approach note that the estimated effects may be biased by the multicollinearity of the variables used and by the effects of omitted variables. To address the problem of multicollinearity, a study[11] used an instrumental variable based on the pre-intervention distribution of deaths by 15 major causes and the dates of global interventions. The study concluded that rising life expectancy accelerates population growth but has only a small effect on GDP, both initially and over a 40-year horizon, largely because land and capital availability does not adjust sufficiently to the accelerated population growth produced by declining mortality. To the extent that the instrument used reflects mainly mortality in childhood, this result seems consistent with those produced by aggregate growth models.

30. An intervention that also affects development, namely, family planning as a component of reproductive health, is not included in the models discussed above. By permitting couples and women to space births and have the number of children they desire, family planning has contributed to reducing maternal mortality and improving child survival. It has also led to reductions in fertility, thus counterbalancing the effect of declining mortality at young ages. Consequently, as economists have shown, it contributes to increasing per capita incomes at both the family and national levels and makes the attainment of both low mortality and low fertility beneficial for development.[12]

31. The association between increasing socio-economic status and better health is remarkably persistent both among countries and within countries. Even within high-income countries, a health gradient exists whereby people having fewer years of schooling, lower-status jobs and lower incomes have worse health than those placed higher in the socio-economic scale. The more time people live in disadvantaged circumstances, the more likely they are to suffer from poor health. Stress in the workplace increases the risk of disease. These effects are stronger in countries with high levels of inequality. To address the socio-economic gradient in health, a holistic approach that goes beyond health policy is necessary to reduce social stratification, including via labour, education, housing and family welfare policies.[13]

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[10] M. J. Jusain, op. cit.

[11] D. Acemoglu and S. Johnson, "Disease and development: the effect of life expectancy on economic growth", *Journal of Political Economy*, vol. 115, No. 6 (December 2007), pp. 925-985.

[12] See E/CN.9/2009/3.

[13] *Closing the Gap in a Generation* (WHO/ER/CSDH/08.1) (World Health Organization, 2008).

VI. The role of primary health care[14]

32. In 1978, at the Alma Ata Conference, the international community defined primary health care as a strategy that would bring essential health care to individuals and families in the community, as close as possible to where they lived and worked, at an acceptable cost, and that would be an integral part of the health system. The Conference also specified the core components of primary health care as health education; environmental sanitation, especially food and water; maternal and child health programmes, including immunization and family planning; prevention of endemic diseases; appropriate treatment of common diseases and injuries; provision of essential drugs; promotion of sound nutrition; and traditional medicine.

33. After the Conference, two major approaches to the implementation of primary health care emerged, namely, a selective approach that focused on the most severe public health problems in a community in order to achieve results quickly, and a comprehensive approach that sought to address the overall spectrum of health problems in a community on a long-term basis. The first approach resulted in the development of vertical programmes to address specific health problems through a limited set of interventions. The second approach, described as "horizontal" or "comprehensive", aimed at creating a system of permanent institutions that would foster the active involvement of the community in improving health not just by treating disease but also by focusing on disease prevention and early detection.

34. Alma Ata's vision has not been easily translated into an effective transformation of health systems and the development of primary health care has stalled in many countries. Over the past 40 years, multilateral, bilateral and private donors have tended to favour vertical programmes for disease control and prevention because they are more likely to produce results over short funding cycles. The expansion of the HIV/AIDS epidemic, in particular, gave added impetus to the vertical approach. Currently, the major international efforts to attain the health Millennium Development Goals are based on disease-oriented vertical programmes, some of which have been detrimental to the primary care system, with which they compete for scarce human and other resources. Vertical programmes that are not integrated into the general health system also create duplication of administrative costs, lead to gaps in care and undermine the Government's capacity to improve its own health-care services. To avoid these detrimental effects, a code of best practice for disease-control programmes has been developed.[15] The code calls for the integration of most disease-control programmes and activities into health centres offering patient-centred care and into not-for-profit health facilities. It also calls for disease-control programmes to be designed and operated in ways that strengthen health systems and that avoid conflict with health-care delivery.

35. The development of comprehensive primary health care in developing countries has also been retarded by the underfinancing of the health sector.

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[14] Based on the *World Health Report 2008* (World Health Organization, 2008); and on J. De Maeseneer and others, "Primary health care as a strategy for achieving equitable care", paper prepared for the Health Systems Knowledge Network of WHO, 2007.

[15] J. P. Unger and others, "A code of best practice for disease control programmes to avoid damaging health care services in developing countries", *International Journal of Health Planning and Management*, vol. 18 (October/December 2003), pp. S27-S39.

especially during the period of structural adjustment. In many contexts, the privatization of health services was promoted based on the view, common among donor agencies, that the private sector could deliver services more efficiently than the public sector. As a result, Governments in both developed and developing countries privatized health services, sub-contracted health care to the private sector, leased or sold public hospitals to the private sector or granted managerial autonomy to public hospitals, blurring the boundaries between public and for-profit objectives. These developments, coupled with the increasing specialization of health professionals at all levels (nurses, physicians, public health agents, etc.), have resulted in health systems that provide uncoordinated access to hospitals and fragmented specialist care mainly to those who can afford it. In developed and developing countries alike, public spending in health often benefits the rich disproportionately compared to the poor and people with means consume more care than the poor, who are afflicted by more health problems. Wherever people have to rely on out-of-pocket payments to cover health-care costs, catastrophic health expenses can lead to poverty. In many countries, health services for the poor are highly fragmented and severely underresourced. In addition, the tendency to cluster resources around curative services that tend to be costly leaves insufficient resources for prevention and health promotion activities that, by one estimate, could prevent up to 70 per cent of the burden of disease.

36. Globally, the share of GDP devoted to health increased from 8 per cent in 2000 to 8.6 per cent in 2005, implying that "the health economy" is growing faster than GDP. Adjusted for inflation, global health expenditure rose by 35 per cent between 2000 and 2005. The rise of non-communicable diseases, most of which are chronic and require long-term treatment and management, has contributed to that increase and the high likelihood that the growth of both the burden of chronic disease and health expenditures will accelerate in the future is a major concern in both developed and developing countries.

37. These developments have prompted policymakers to renew their support for a comprehensive primary health-care approach to counteract the fragmentation of health systems, achieve health equity, promote health security at the community level, and provide a comprehensive and coordinated response to the health-care needs of individuals and their families. To achieve these goals, the primary health-care approach needs to be used as a flexible guiding framework so that it can be adapted to local needs and specific sociocultural contexts. To be comprehensive, primary health care must integrate individual and population-based care by blending the clinical skills of physicians with epidemiology, preventive medicine and health promotion. In principle, primary health care would be part of a district health system and the first point of contact with patients. It would take care of most of the cases presented and direct the rest to secondary- and tertiary-care facilities in a cost-effective manner and ensuring continuity of care. Interdisciplinary teams, including family physicians, nurses, social workers and nutritionists, would provide continuous, seamless care focusing on health promotion, disease prevention, treatment of acute conditions and the long-term treatment and management of chronic diseases. Through intersectoral cooperation, primary health-care actors would identify community problems affecting health and advocate for solutions.

38. A comprehensive primary health-care approach can save money. In high-income countries with a strong primary health-care orientation, health expenditure per capita is less on average than in other high-income countries. In

addition, maximal access to primary health care with sufficient referral opportunity decreases health inequality.[16] In the United States of America, for instance, higher ratios of family physicians to population are associated with better health outcomes in areas with higher income inequalities. Evidence from developing countries corroborates the potential of primary health care to reduce health disparities. In Mexico, for instance, access to primary care facilities and continuity of care backed by adequate referral mechanisms have contributed to reducing child mortality in deprived populations.

39. To institute comprehensive primary health care and reap its potential benefits, a number of reforms are needed. First, there is a need to ensure that all people have access to primary health through financing methods that ensure universal coverage and are based on risk-sharing. Second, the delivery of health services has to be reformed to ensure that health systems respond to the actual needs of people. Third, Governments must remain committed to undertake public policy reforms so as to integrate public health actions and primary care. Fourth, leadership in the health field must remain responsive to community needs by encouraging the active participation of community members. The leadership should also work towards improving health through policies in other sectors, including education, food safety and quality, tobacco and alcohol control.

40. Today, in high-income countries whose health expenditure is high, there is ample room to shift resources from tertiary to primary care and ensure universal coverage.[17] The challenge is greater but more pressing in middle-income countries, where 3 billion people live and where health systems need to adapt to new demands. In doing so, following a primary care approach and ensuring universal coverage are key strategies to avoid the mistakes of the past. Lastly, in the low-income countries, particularly those in sub-Saharan Africa and Southern Asia where 2 billion people live, emphasis on a comprehensive primary care approach is essential to ensure health equity. In all countries where universal coverage is not yet a reality, there is a need to shift from reliance on user fees levied on patients to the protection provided by pooling resources and prepayment. Low-income countries, which at present are unable to cover the costs of essential health services, will require external assistance to effect needed change.

VII. The need for health workers[18]

41. The health workforce includes all people who provide health services — doctors, nurses, physical therapists, pharmacists, laboratory technicians — as well as management and support workers needed for the functioning of health services. In 2006, WHO estimated that there were 60 million health workers globally, 40 million providing health services and 20 million working in management and other support activities. However, health workers are not equitably distributed either among countries or within countries. High-income countries have more health workers per population than other countries. Within all countries, health workers

[16] B. Starfield, L. Shi and J. Macinko, "Contribution of primary care to health systems and health", *Milbank Quarterly*, vol. 83, No. 3 (2005), pp. 457-502.

[17] *World Health Report 2008* (World Health Organization, 2008), Introduction and Overview.

[18] Based on "The global shortage of health workers and its impact", WHO Fact sheet No. 302, April 2006; and "Migration of health workers", WHO Fact sheet No. 301, April 2006.

tend to be concentrated in larger cities, while small cities and rural areas face shortages. According to WHO, 57 countries, most of them located in Africa and Asia, lack sufficient health workers to meet the health needs of their populations. In 2006, according to WHO, an additional 2.4 million health service providers and 1.9 million management and support workers were needed by those countries. Those shortages are a major barrier to the achievement of the health Millennium Development Goals and make it difficult to develop and sustain the primary health infrastructure needed to reduce inequities in access to health care.

42. It is urgent to increase investment in the training and support of health workers, including by increasing their salaries and providing incentives to those who work in underserved areas. Assuming that the additional 4.3 million workers needed by the 57 countries facing severe shortages are trained over two decades, health budgets would need to increase by US$ 10 per person per year. In addition to funding, comprehensive plans for the development and maintenance of an effective health workforce need to be drawn up and implemented by committed political leaders. Such plans should ensure that the orientation of health-worker training is appropriate for the contexts in which they will work and that career incentives are included to encourage health workers to serve away from large cities.

43. There is also a need to train existing workers in all countries so that they keep up to date with new treatments and practices. Improved management and supervision are necessary to make more efficient use of human resources, particularly in the context of comprehensive primary health care where new team care models need to be introduced and evidence-based skills for the holistic management of disease need to be imparted. Health workers with advanced communication abilities, able to use techniques to effect behavioural change and to educate patients, and who have counselling skills are needed the world over to provide care for chronic conditions.[19] Task shifting, whereby highly skilled personnel delegate health-care tasks to less skilled workers who can master them, is also necessary, particularly when, with sufficient supervision and support, volunteers or community health workers can perform those tasks effectively.

44. Because health workers are in demand in richer countries where salaries are better, health workers from middle- and low-income countries have been migrating to high-income countries. Health systems in some high-income countries have high shares of doctors and nurses trained abroad. Given that people have the right to leave their countries, the cooperation of countries of origin and destination is necessary to reduce the negative impacts of health-worker migration. Countries of origin need to improve the working conditions of health workers, train more and orient training to the circumstances in which they will work (e.g. for rural postings). Donors can provide funding for these purposes. Countries of destination need to train more physicians and nurses locally and should follow responsible recruitment practices. An international code of practice for the recruitment of health personnel is in the process of being established.[20]

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[19] *Innovative Care for Chronic Conditions: Building Blocks for Action* (World Health Organization, 2002).

[20] International recruitment of health personnel: draft global code of practice — report by the Secretariat (EB 124/13) (World Health Organization, 2008).

VIII. Prevention and treatment of communicable diseases and maternal conditions

45. Communicable diseases cause 23 per cent of all deaths and 57 per cent of those among children under 5. Yet most communicable diseases are preventable, treatable or curable with low-cost interventions. It is universally recognized that communicable diseases exact a major toll on the health of the poor and the Millennium Development Goals focus on the prevention and control of the major killers. However, progress towards their achievement is falling short and the Millennium Development Goals do not address all communicable diseases. The key interventions to combat the major communicable diseases, alone or in clusters, are reviewed below.

46. ***HIV/AIDS***. In 2008, about 33 million people were living with HIV, 22 million of whom lived in sub-Saharan Africa.[21] That year, 2.7 million people became newly infected with HIV and AIDS killed 2 million persons, down from a peak of 2.2 million in 2004. Half of those living with HIV are women and half of new infections occur among young people aged 15 to 24. To prevent the spread of HIV, a multipronged strategy is necessary. It includes education and information campaigns to improve understanding of how HIV spreads and how people can protect themselves, focused programmes to reduce high-risk behaviours, the screening of blood products, preventing the reuse of infected needles, providing access to voluntary counselling and testing to determine who is infected, providing treatment for those who need it and preventing mother-to-child transmission by treating HIV-positive pregnant women. Success in avoiding a generalized epidemic has hinged on reaching high-risk groups, including commercial sex workers and injecting drug users. In countries with generalized epidemics, access to antiretroviral therapy for those who need it has expanded markedly. In 2008, an estimated 42 per cent of the 9.5 million persons requiring therapy[22] were receiving it. Increase in antiretroviral therapy coverage has accelerated thanks to reductions in the price of antiretroviral drugs, such as those negotiated by the Clinton Foundation HIV/AIDS Initiative and the International Drug Purchase Facility (UNITAID) in 2007. This effort and the provision of diagnostics will need to be scaled up further and sustained over the long term in order to ensure that people continue to survive with HIV. At the same time, prevention efforts must be strengthened, including by facilitating access to condoms and treating sexually transmitted diseases.

47. ***Tuberculosis***. In 2007 there were 9.3 million new cases of tuberculosis, 15 per cent of which occurred in HIV-positive persons. If diagnosed early, tuberculosis is curable. Thus, a strategy to eradicate tuberculosis must incorporate both early detection and expeditious use of the Directly Observed Treatment Shortcourse, which is highly effective in curing the disease. A growing concern is the increasing prevalence of multi-drug-resistant tuberculosis, which affected 3 per cent of newly infected people and 19 per cent of recurring infections in 2007. Both diagnosing this variant of the disease and treating it is costly and demanding. A number of organizations, including the Stop TB Partnership, the Global Fund to Fight AIDS,

[21] *2009 AIDS Epidemic Update* (Joint United Nations Programme on HIV/AIDS and World Health Organization, 2009).

[22] HIV infection takes years to weaken the immune system. Therapy is indicated only after there are clear signs of immune system decline.

Tuberculosis and Malaria and UNITAID work to provide drugs for treating drug-resistant tuberculosis.

48. ***Malaria***. In 2008, there were 243 million malaria cases, which caused 863,000 deaths, four fifths of which were among children under 5.[23] Nine out of every 10 malaria cases occur in sub-Saharan Africa. Malaria in pregnant women is associated with maternal anaemia and preterm delivery, leading to low birth weight and increased infant mortality. Controlling the spread of malaria involves early diagnosis, effective treatment and prevention of transmission by using long-lasting insecticide-treated bednets and indoor residual insecticide spraying. Because of growing antimalarial drug resistance, in Africa and Asia the only effective treatment for malaria is artemisinin-based combination therapy (ACT), which costs more than drugs that have lost effectiveness.[24] Efforts are under way to scale up ACT treatment, particularly by providing intermittent preventive treatment to pregnant women in high transmission settings and paediatric ACT treatment to children. Expansion of bednet coverage is also being pursued. According to the Roll Back Malaria Partnership, over 700 million bednets need to be deployed by 2010 to dent the spread of the disease.

49. ***Neglected tropical diseases***. A number of infectious and parasitic diseases, endemic in tropical areas, exact a toll on affected populations by causing chronic morbidity. They include soil-transmitted helminthes (hookworm infection, ascariasis and trichuriasis) and schistosomiasis, all of which cause anaemia among pregnant women and impair physical and cognitive development in children; lymphatic filariasis, which causes severe leg swelling; trachoma and onchocerciasis, which cause blindness; Chagas disease, which affects the digestive system and heart function; leishmaniasis, which causes skin lesions and ulcers; human African trypanosomiasis (sleeping sickness), and dengue fever, a viral infection. About a billion people suffer from one or more of those diseases or their sequelae.[25] If left untreated, parasite infections can last decades and cause severe disability. They also increase susceptibility to other diseases, including HIV and malaria. Crucially, most of these tropical diseases can be prevented or treated. Access to safe water and basic sanitation reduce the incidence of schistosomiasis and trachoma. Vector control can reduce the transmission of dengue, sleeping sickness and Chagas disease. Single doses of low-cost drugs are effective in treating lymphatic filariasis, soil-transmitted helminthes and onchocerciasis, making possible their control via mass drug administration to affected communities or in schools. Because these diseases are debilitating but do not cause death, efforts to control or treat them are not getting sufficient support.

50. ***Communicable causes of child mortality***. The main causes of child mortality are acute respiratory infections and diarrhoeal diseases, each accounting for 17 per cent of all child deaths. Vaccines have virtually eliminated pneumonia in developed countries, but are not yet widely used in many developing countries where poverty, inadequate nutrition and indoor air pollution contribute to a high incidence of lower respiratory infections. Improving child nutrition and indoor air quality can reduce the incidence of severe respiratory infections and, when infection strikes, early diagnosis and treatment with antibiotics and oxygen can prevent severe

[23] *World Malaria Report 2009* (World Health Organization, 2009).

[24] Ibid.

[25] Peter J. Hotez, *Forgotten People, Forgotten Diseases* (Washington, D.C., ASM Press, 2008).

illness and death. A properly functioning primary health-care system would provide such treatment. As for diarrhoeal diseases, their main causes are pathogens transmitted from person to person when faecal matter contaminates water, food or a person's hands. Basic hygiene, including hand washing, and access to safe water and sanitation can dramatically reduce morbidity and mortality from diahrroeal diseases. When diarrhoea occurs, oral rehydration therapy and zinc supplementation, used in combination with exclusive breastfeeding for infants, nutritional support, and appropriate use of antibiotics, can prevent the progression to severe illness and death. To prevent other major childhood diseases, vaccines have proved successful. Measles, another major cause of child mortality, can be prevented by two doses of a vaccine. In 2007, 82 per cent of children aged 12 to 23 months had received at least one dose of the vaccine. Vaccines are also effective in combating polio, diphtheria, pertussis and tetanus. National vaccine campaigns are examples of vertical programmes that are effective, especially in low-income settings.

51. ***Maternal conditions***. Although maternal mortality accounts for just 2 per cent of female deaths worldwide, most of the 536,000 women who died in 2005 of maternal causes could have been saved if they had had access to appropriate care. Virtually all maternal deaths occur in developing countries and half in sub-Saharan Africa. Little progress has been made in reducing maternal mortality since 1990. Lack of appropriate obstetric care is the major immediate cause of maternal mortality and morbidity. Globally 300 million women suffer from the sequelae of pregnancy and childbirth and 20 million new cases occur annually. Sequelae include infertility, severe anaemia, uterine prolapse and vaginal fistula. Anaemia, which affects 42 per cent of pregnant women and is often exacerbated by malaria, HIV and other conditions, increases the risk of maternal death from haemorrhage. Globally, 33 million women in developing countries are infertile because of complications from unsafe abortion and maternal sepsis. Assistance from skilled health workers (doctors, nurses or midwives) at delivery is crucial for reducing maternal mortality. In both Southern Asia and sub-Saharan Africa, where the largest number of maternal deaths occur, fewer than half of all births are attended by skilled health workers. To be effective in preventing deaths and addressing complications, skilled personnel must have the proper equipment and be able to refer and transport women presenting complications to emergency obstetric services. Access to such services is still limited in low-income countries. Especially in those settings, providing women with family planning options to avoid mistimed or unwanted pregnancies is a cost-effective intervention to reduce maternal morbidity and mortality. Nearly 53 million unintended pregnancies could be averted annually if the unmet need for family planning in developing countries were satisfied, resulting in the prevention of 150,000 maternal deaths.[26] Provision of both antenatal care and post-natal counselling, education and access to effective contraceptive methods for women who want them are all necessary to improve reproductive health and reduce maternal mortality and morbidity.

[26] Guttmacher Institute and United Nations Population Fund, *Adding it Up. The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health* (2009).

IX. Prevention of non-communicable diseases

52. As a group, non-communicable diseases already cause 60 per cent of deaths worldwide and 72 per cent of those in middle-income countries, and their share of the burden of disease is expected to increase in the future. Among them, cardiovascular diseases, cancers, chronic respiratory diseases, diabetes and depression represent the leading threats to human health and development. Non-communicable diseases pose a major economic and social burden because most are chronic and require long-term treatment. Yet up to 80 per cent of heart disease, stroke and type 2 diabetes and over a third of cancers could be prevented by eliminating shared risk factors, especially tobacco use, unhealthy diets and physical inactivity. In addition, advances in biomedical and behavioural management have substantially increased the ability of health interventions to prevent and control these diseases, especially when patients receive effective treatments, self-management support and regular follow-up.

53. As populations age, more people are living with one or more chronic conditions for decades. The increase in sedentary living associated with growing urbanization, the prevalence of unhealthy diets and the global marketing of health risks, such as tobacco, are also factors contributing to that increase. The result is higher demands placed on national health systems and higher health-care expenditures. In addition, because over time adverse risk behaviours tend to become concentrated in the poorer segments of the population, chronic diseases are intertwined with poverty and can, in turn, exacerbate poverty through high treatment costs that need to be sustained over long periods. The increase in chronic conditions in middle- and low-income countries is particularly challenging because many of those countries still have a significant burden of disease from acute infectious diseases, maternal conditions and malnutrition.

54. National policies in sectors other than health exert a significant and often determining influence in shaping the risk factors for non-communicable disease. Thus, health improvements depend on public policies related to trade, taxation, education, agriculture, urban development, food and pharmaceutical production. Intersectoral action is therefore key in national planning to reduce the burden of non-communicable disease. For instance, changing diets, reducing the prevalence of obesity and increasing physical activity requires achieving behavioural change through changes in food production, marketing and advertising; dissemination of nutritional information; access to health education, and the planning of urban environments and public transportation. In 2004, the World Health Assembly adopted the Global Strategy on Diet, Physical Activity and Health[27] to provide guidance in addressing those factors.

55. Tobacco use is the single most preventable cause of death in the world since it is a risk factor for all the major non-communicable diseases. While prevalence of smoking has declined in many developed countries and has stabilized or declined slightly among men in much of the developing world, it is increasing among women both in developing countries and in countries of Central and Eastern Europe.[28] Without a sustained decline in prevalence, the number of smokers will increase with the growth in the world population. Because tobacco use is addictive, smokers find it difficult to stop. Therefore, preventing people, especially the young, from taking

[27] Resolution WHA57.17, annex.

[28] J. Mackay and M. Eriksen, *The Tobacco Atlas* (World Health Organization, 2002).

up smoking is crucial. There is strong commitment among Governments to reduce the spread of tobacco use: as of November 2009, 168 Governments had ratified the WHO Framework Convention on Tobacco Control.[29] The Convention contains provisions for the reduction of both the demand for and the supply of tobacco. Taxing tobacco is one of the most cost-effective health measures that Governments can take.

56. Small shifts in average levels of risk factors can produce major changes in the burden of non-communicable diseases. Strategies to combat these diseases should aim both at reducing national levels of risk factors and preventing disease in high-risk individuals. Such strategies include changes in laws and regulations; tax and price interventions; advocacy and education; interventions in communities, schools or workplaces; and screening, clinical prevention and disease management. Several elements of these strategies can be implemented even in low-income countries. Intersectoral coordination under a unifying national action plan is necessary to avoid duplication of efforts. The WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases provides guidance for action by each of the different actors involved.

57. To underline the importance of reducing the major risk factors for non-communicable diseases, their specificity in terms of the major components of the burden of disease is discussed below.

58. ***Cardiovascular diseases***. Cardiovascular diseases account for the largest share of deaths globally: 32 per cent of female deaths and 27 per cent of male deaths in 2004. The biggest killers are heart attacks and strokes, which caused 7 million and 6 million deaths, respectively, in 2004. The major risk factors for cardiovascular diseases are hypertension and high cholesterol levels, which are in turn associated with diets rich in fats and sodium, sedentary lifestyles and tobacco use. The damage caused by diabetes also causes heart disease. High-income countries have reduced rates from cardiovascular disease through a combination of prevention and treatment. Preventive measures include promoting non-smoking environments, healthier diets and increased physical activity, lifestyle changes that have been adopted by important segments of the population. In addition, the systematic treatment of hypertension and high cholesterol has been effective in delaying illness. Nevertheless, the rising levels of obesity and diabetes in much of the world portend increasing difficulties in continuing to reduce the toll of cardiovascular diseases.

59. ***Diabetes***. Diabetes occurs when the body does not produce insulin to process glucose (type 1) or cannot use efficiently the insulin that it produces (type 2). Left untreated, diabetes causes high blood glucose levels that, over time, damage the circulatory and nervous systems. In 2004, 220 million people had diabetes and 1.1 million deaths were directly attributable to the disease. Yet up to 2.9 million deaths may be attributed directly or indirectly to diabetes and its complications, including heart disease and kidney failure. Without proper screening, diabetes very often goes undetected until it has damaged key body systems. Once detected, diabetes and its complications require long-term treatment and continuous management, including through changes in diet and lifestyle. The rising global incidence of diabetes is associated with the increasing prevalence of obesity, particularly in high- and middle-income countries.

[29] Adopted by the World Health Assembly on 21 May 2003.

60. ***Chronic obstructive pulmonary disease and cancers related to smoking***. Chronic obstructive pulmonary disease is a life-threatening lung disease that interferes with normal breathing. In 2004, it caused 3 million deaths, 90 per cent of which occurred in low- and middle-income countries, affecting men and women alike. Because the primary cause of the disease is smoke inhalation, whether from tobacco use or indoor cooking fires, reducing tobacco use and subsidizing the use of cleaner cooking fuels by poor people can prevent the disease. The same is true for the array of cancers most closely related to tobacco use: those of the trachea, bronchus, lung, mouth and oropharynx. In 2004, they accounted for 29 per cent of all cancer deaths and for 34 per cent of those in Asia, excluding Western Asia. Tobacco use is an important cause of excess male mortality. Globally, 80 per cent of smokers are male and the majority of smokers live in developing countries.

61. ***Cancers of the reproductive system***. Cancers of the breast, cervix, uterus and ovaries accounted for 18 per cent of all new cases of malignant neoplasms in 2004 and for 13 per cent of the deaths from cancer. Prostate cancer contributed 5 per cent of the new cancer cases and 4 per cent of all cancer deaths. These cancers are the most common among neoplasms in Africa, accounting for 45 per cent of cancer deaths among women and 21 per cent of those among men in that region. Globally, breast cancer is the second most common cancer, accounting for 1.1 million new cases and 520,000 deaths annually, nearly all among women. Early diagnosis of breast cancer improves prognosis and requires mammography screening of women aged 50 to 74. Cervical cancer is the second most common cancer in women worldwide, accounting for about 500,000 new cases and 250,000 deaths annually. More than 4 out of every 5 cervical cancer cases occur in low-income countries and it is the most common type of cancer in Africa and Southern Asia. Mortality from cervical cancer is also higher in the developing world, primarily because effective screening for the disease is rare in developing countries. Cervical cancer is caused by the human papilloma virus (HPV) and a vaccine against it already exists. Some countries have begun vaccination programmes but it is too early to assess their effectiveness. Among men, prostate cancer is the major cancer of the reproductive system and it develops at older ages, with most deaths occurring after age 70. Because it is generally a slow growing cancer, generalized screening is no longer recommended.

62. ***Other cancers***. In 2004, 64 per cent of cancer cases involved organs other than the lungs or those in the reproductive system. Risk factors for other cancers vary. Overweight and obesity are associated with several types of cancer, including cancer of the oesophagus, colorectum, breast, endometrium and kidney. High intake of preserved meat or red meat is associated with increased risk of colorectal cancer. The composition of the diet is important because fruit and vegetables appear to have a protective effect, decreasing the risk of developing oral, oesophageal, stomach and colorectal cancers. High consumption of alcoholic beverages has been shown to increase the risk of cancers of the oral cavity, pharynx, larynx, oesophagus, liver and breast. Exercise has been found to reduce the risk of colorectal cancer. Certain infective or parasitic agents are linked to cancer: viral hepatitis B and C cause cancer of the liver; the bacterium Helicobacter pylori increases the risk of stomach cancer; schistosomiasis increases the risk of bladder cancer, and liver fluke infection increases the risk of cancer of the bile ducts. Exposure to ionizing radiation can give rise to certain cancers and excessive solar ultraviolet radiation increases the risk of all types of skin cancer. The identification of the different risk factors provides the

basis for interventions aiming to reduce their prevalence in the population. Controlling weight and avoiding weight gain in adulthood by reducing caloric intake and by increasing physical activity is protective against cancer. Promoting healthier diets and exercise; vaccinating against hepatitis B; increasing awareness about the dangers of excessive sun exposure, and taxing alcoholic beverages to reduce consumption are all measures that can reduce the incidence of cancer.

63. ***Neuropsychiatric disorders***. Globally, neuropsychiatric disorders account for 13 per cent of the disability adjusted life years and depression is responsible for a third of their impact. Despite being important causes of disability, mental disorders do not receive the attention they deserve, particularly in middle- and low-income countries. The stigma that is often attached to mental disorders prevents people from seeking treatment and family doctors are usually not sufficiently trained in recognizing and managing mild to moderate mental disorders. Effective drugs exist today to treat an array of mental disorders and symptom-focused psychotherapies, such as cognitive-behavioural therapy, have proved to be effective in treating certain disorders. To ensure that mental disorders are not disregarded by the health system, health authorities should develop a mental health policy; integrate mental health treatment into primary health care; budget for workforce development and essential drug procurement, and train primary health-care providers in mental health.

X. Preventing injuries

64. Unintentional and intentional injuries cause more than 5 million deaths each year and several million temporary or permanent disabilities that require hospitalizations, emergency department visits and the use of other health services. While morbidity and mortality from unintentional injuries and violence are public health concerns in all populations of the world, their prevalence and consequences disproportionately affect developing countries where unsafe living and working conditions are common. In 2004, the risk of dying from an unintentional injury was nearly twice as high in low-income and middle-income countries as in high-income countries. Young men are particularly at risk of experiencing unintentional injuries or violence. Eight of the 14 leading causes of death among males aged 15 to 29 in 2004 were injury related, including road traffic accidents, homicides and suicides.

65. Among the 5.8 million deaths caused by injuries in 2004, road traffic accidents caused 1.3 million. Alcohol use is a major contributor to deaths from both unintentional injuries and violence. The use of alcohol causes 1.8 million deaths annually and 32 per cent of them are from unintentional injuries, many of them involving traffic accidents. In 2004, WHO made recommendations on measures to reduce traffic accidents in the *World Report on Road Traffic Injury Prevention*. Governments are urged to enact comprehensive laws to protect all road users, including pedestrians, by setting appropriate speed limits and blood alcohol concentration limits, and by requiring the use of appropriate protection mechanisms, including helmets, seat belts and child restraints.

66. Unintentional injuries other than road traffic accidents, such as poisonings, drownings, fires and falls, caused 2.6 million deaths in 2004. To prevent injuries among children, the use of child-resistant containers to prevent poisoning and pool fencing to prevent drowning are recommended. So is the elimination of home hazards to prevent falls, especially among children and the elderly.

67. Reducing the number of injuries and deaths due to violence requires multi-sectoral and culturally appropriate strategies. Programmes to restrict access to common methods of suicide and interpersonal violence, such as guns, are effective in reducing mortality from intentional injury. School-based educational programmes to improve self-esteem, control anger and develop appropriate conflict resolution skills can prevent violence among young people, including between those who are intimate partners. It is also crucial to treat those suffering from depression and other mental disorders and to establish crisis centres that can provide immediate support to victims or potential victims of suicide or violence.

XI. Conclusions and recommendations

68. **The universal decline in mortality that occurred in most countries during the twentieth century has led to life expectancies at or above 69 years in all world regions, except Africa, and to a shift of mortality from the younger to the older ages. Underpinning this transition is the effective control and treatment of the major communicable diseases with the result that in all world regions, except Africa, they account for moderate to low proportions of all deaths (27 per cent or less). Similarly, their share of the burden of disease is a low 22 per cent in middle-income countries and just 6 per cent in high-income countries.**

69. **The decline in the burden of disease attributable to communicable diseases has been accompanied by a rise in that associated with non-communicable diseases, most of which are chronic and require long-term treatment. Among non-communicable diseases, neuropsychiatric disorders and cardiovascular diseases, especially heart attacks and stroke, account for a major share of the burden of disease in high- and middle-income countries. Cancers, chronic respiratory diseases and diabetes are other major contributors to the burden of disease in those countries.**

70. **In sub-Saharan Africa, the transition to low mortality had not advanced as rapidly as in other regions by 1980 and the emergence of the HIV/AIDS epidemic slowed down or even reversed in some African countries the gains made during previous decades. Despite the major advances made in reducing the spread of HIV and treating those affected, 2.7 million new cases of the disease still occur annually and, for those receiving treatment, HIV infection has become a chronic condition requiring long-term treatment. Among low-income countries, which include most of those in sub-Saharan Africa and India, 57 per cent of the burden of disease is attributable to communicable disease, including HIV/AIDS, and maternal and perinatal conditions, and an additional 33 per cent is caused by non-communicable diseases. Low-income countries face therefore the double challenge of preventing the spread of communicable diseases and treating those affected while at the same time addressing the growing prevalence of chronic, non-communicable diseases.**

71. **In all countries, the poorer segments of the population are more vulnerable to disease and have less means to prevent or treat it. Yet health expenditure tends to favour the rich. Therefore, all countries face the challenge of reducing inequities in access to health care and instituting financing**

mechanisms that ensure universal coverage based on risk-sharing so as to prevent illness from leading to poverty.

72. A key strategy in addressing these multiple challenges is to strengthen health systems to ensure that they can deliver the services communities require, including not only curative care and the treatment of acute conditions but also preventive care, health promotion and the long-term management of chronic conditions. A comprehensive primary health-care approach offers a flexible framework to achieve these objectives. To be comprehensive, primary health care must integrate individual and population-based care, blending the clinical approach with epidemiology, preventive medicine and health promotion. It should be the basis of a district health system, with capacity to treat most cases and adequate referral support from secondary- and tertiary-care facilities. It should ensure a holistic approach to health maintenance, disease prevention and the management of chronic conditions through interdisciplinary practice and continuity of care.

73. A comprehensive primary health approach is cost-effective but it can be developed only through a sustained and focused effort over the medium term. For that reason, pressing needs have been mostly addressed through vertical programmes focusing on specific diseases, to the detriment of a comprehensive approach. Because pressing needs are real, health planners and donors need to find novel ways of integrating their interventions into primary health facilities or, when vertical programmes are appropriate, ensuring that they do not adversely affect efforts to strengthen primary health care. In countries depending on donor funding to boost health budgets, continuity of funding is necessary to ensure that efforts to develop a comprehensive primary health-care system are sustained.

74. A crucial element in the strengthening of health systems is the availability of the necessary health workforce. Shortages of health workers are severe in many low-income countries but they also exist in high-income countries because of the increasing burden of chronic disease among their ageing populations. There is a need, therefore, for concerted efforts at both the national and the international level to train an adequate supply of health workers, ensuring that training produces the variety of skills needed and that it is oriented to the contexts in which health workers are required. Devising incentives for health workers to take jobs and remain in underserved areas, especially the rural areas of developing countries, is also necessary. Donor funding can assist Governments of low-income countries to implement national plans on health workforce retention and development. High-income countries should follow responsible recruitment practices it order not to exacerbate the shortages of health workers in low-income countries.

75. In low-income countries, the current priority is to achieve the health Millennium Development Goals and efforts to do so are well under way. Funding for a number of interventions has been growing but is not yet adequate. Scaling up successful interventions is required. The full array of actions needed has been reviewed in the body of this report. One intervention that bears highlighting is support for family planning programmes in the least developed countries. Donor funding for family planning has declined since the mid-1990s and the unmet need for modern contraception remains high in the

least developed countries: one out of every four women aged 15 to 49 who are married or in a union have such an unmet need.[30] By preventing mistimed or unwanted pregnancies, family planning can contribute to reducing maternal mortality by 28 per cent and, by extending inter-birth intervals, it can contribute to reducing child mortality. For every dollar spent in family planning, from 2 to 6 dollars can be saved in interventions to achieve other Millennium Development Goals.[31]

76. **The most cost-effective strategy to reduce the growing burden of chronic, non-communicable disease is to reduce the prevalence of the risk factors associated with the most common diseases. Tobacco use, unhealthy diets, overweight and obesity, physical inactivity and excessive use of alcohol all contribute to raising the risks of the major causes of chronic disease. National policies in sectors other than health exert a significant and often determining influence in shaping those risk factors. Thus, health improvements depend on public policies related to trade, taxation, education, agriculture, urban development, food and pharmaceutical production. Intersectoral action is therefore key in national planning to reduce the burden of non-communicable disease. Guidance on how to improve diets and promote physical activity can be found in the Global Strategy on Diet, Physical Activity and Health adopted by the World Health Assembly in 2004. Provisions to reduce both the demand for and the supply of tobacco are contained in the WHO Framework Convention on Tobacco Control and taxing tobacco is one of the most cost-effective health measures that Governments can take. The WHO 2008-2013 Action Plan for the Global Strategy for the Prevention and Control of Noncommunicable Diseases lists actions appropriate for all actors concerned.**

77. **Mental disorders, especially depression, are responsible for an important share of the burden of disease yet mental health treatment is rarely well integrated into the health systems of medium- and low-income countries. Effective drugs exist today to treat an array of mental disorders. To ensure that mental disorders are not disregarded by the health system, health authorities should develop a mental health policy, integrate mental health treatment into primary health care, budget for workforce development and essential drug procurement, and train primary health-care providers in mental health.**

78. **Injuries remain a significant cause of death in all groups of countries but exert a heavier toll in middle-income countries. Road traffic accidents account for a fifth of all deaths due to injuries and could be reduced significantly by enacting and enforcing regulations setting appropriate speed limits and blood alcohol concentration limits, and requiring the use of appropriate protection mechanisms, including helmets, seat belts and child restraints. Reducing the use of alcohol and eliminating unsafe housing or working conditions is also important. Restricting access to common methods of suicide and interpersonal violence, such as guns, is effective in reducing mortality from intentional injury.**

[30] "What would it take to accelerate fertility decline in the least developed countries?" (United Nations Population Division Policy Brief, No. 2009/1).

[31] Scott Moreland and Sandra Talbird, "Achieving the Millennium Development Goals: the contribution of fulfilling the unmet need for family planning" (Washington, D.C., USAID, 2006).

79. **In sum, if mortality is to continue declining in all countries, the burden of disease will become even more dominated by non-communicable diseases, most of which are chronic and require long-term treatment and management. Since death is inevitable and there are as yet no means of eradicating specific non-communicable diseases, delaying the onset of illness should be the main objective. Fortunately, Governments can do much to achieve that objective, especially by taking measures to reduce the prevalence of risk factors associated with chronic disease. Most of those measures relate to sectors other than health and are cost-effective. Implementing them as soon as possible will buy time to strengthen health systems so as to provide more equitable and effective care to all those who need it.**

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Actions in follow-up to the recommendations of the International Conference on Population and Development

Monitoring of population programmes, focusing on health, morbidity, mortality and development

Report of the Secretary-General

Summary

The present report on the monitoring of population programmes, focusing on health, morbidity, mortality and development has been prepared in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its decision 2009/239. In its decision 2008/101, the Commission decided that health, morbidity, mortality and development should be the special theme for the forty-third session of the Commission.

The report provides an overview of the programmatic work of the United Nations Population Fund to improve maternal health and reduce morbidity and mortality. It focuses on activities related to maternal and newborn care, investing in family planning and midwifery, enhancing reproductive health commodity security, preventing and treating obstetric fistula, abandoning the practice of female genital mutilation/cutting, eliminating gender-based violence, addressing adolescent pregnancy and child marriage, preventing mother-to-child transmission of HIV, comprehensive condom programming to prevent unintended pregnancy and HIV infection and providing reproductive health services in emergency situations.

It points out that reproductive ill health impacts mortality and accounts for a large share of the global burden of disease, particularly among women and children. The most cost-effective interventions to reduce maternal mortality are family planning, skilled birth attendants during delivery and emergency obstetric care.

* E/CN.9/2010/1.

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Contents

I. Introduction
II. Maternal health and family planning
III. Obstetric fistula
IV. Female genital mutilation/cutting
V. Gender-based violence
VI. Adolescent pregnancy and child marriage
VII. HIV/AIDS prevention
VIII. Reproductive health in emergencies
IX. Conclusion

I. Introduction

1. The present report on the monitoring of population programmes, focusing on health, morbidity, mortality and development has been prepared by the United Nations Population Fund (UNFPA) in response to the topic-oriented and prioritized multi-year work programme of the Commission on Population and Development, which was endorsed by the Economic and Social Council in its decision 2009/239. The special theme for the forty-third session of the Commission was adopted by the Commission in its decision 2008/101.

2. Reproductive ill health impacts mortality and accounts for a large share of the global burden of disease, particularly among women and children. Poverty and gender discrimination exacerbate reproductive health problems. Violence against women and girls also negatively affects their sexual and reproductive health and can result in other chronic health and mental health problems.

3. Sexual and reproductive health interventions are a good investment and the benefits of such interventions are far-reaching. Besides the obvious medical benefits, they contribute to achieving broader development objectives, including higher levels of education, social equity, economic growth and productivity. Family planning services allow women to achieve higher education and combine child-rearing with employment. Antenatal, obstetric and neonatal care results in an increase in healthy years of life due to reduction in disability and premature death among women and their newborns. HIV prevention and treatment programmes reduce morbidity and mortality stemming from the AIDS pandemic and other sexually transmitted diseases.[1]

4. In many developing countries, weak health systems fail to address the needs of women and marginalized groups because they do not provide appropriate, accessible and affordable sexual and reproductive health services. Indeed, constraints in health system performance are increasingly recognized as a major contributing factor to the delays in achieving better health outcomes and the health-related Millennium Development Goal targets. Severe underinvestment in national health systems has adversely impacted the capacity of countries to provide quality and accessible health services, particularly for the poor and marginalized. This has been further weakened by the often limited alignment between donor aid and country priorities, unbalanced funding of different services, fragmentation and unpredictability, all of which have weakened national ownership and long-term sustainability.

5. The Fund has adopted national capacity development as an overarching principle of its assistance to country-led processes and policy dialogue as an important approach to integrate the International Conference on Population and Development agenda and related Millennium Development Goals more effectively into national development frameworks (including poverty reduction strategy papers) and relevant sector planning frameworks. Emphasis is placed on the integration of all elements of reproductive health into the national and subnational health planning processes, including the costing of maternal health roadmaps and reproductive health strategies. The Fund seeks to strengthen the capacity of its staff and country counterparts to position sexual and reproductive health/Millennium Development

[1] Guttmacher Institute and United Nations Population Fund (2009). *Adding it Up: The Costs and Benefits of Investing in Family Planning and Maternal and Newborn Health*.

Goals 4, 5 and 6 in national policies, plans and budgets to ensure that increasing attention and resources are programmed at all levels of the system. UNFPA is addressing weaknesses in procurement systems, utilizing reproductive health commodities as an entry point to address capacity constraints and weak coordination while addressing broad synergies, particularly in the area of HIV/AIDS.

6. In addition, UNFPA is disseminating best practices to enhance capacity in the area of health system strengthening and innovative financing to increase access to sexual and reproductive health and rights services and reduce out-of-pocket payments. In a number of countries, UNFPA is working on strengthening health information systems, including facility-based data and surveys, to ensure that quality data are available to inform the planning, budgeting and monitoring processes.

7. UNFPA works with many partners, both within and outside the United Nations system, including Governments, non-governmental organizations, civil society, faith-based organizations, religious leaders and others, to achieve its mission. To better respond to local needs, UNFPA increasingly devotes resources to country-led efforts, placing emphasis on country-focused and country-led implementation to achieve improved results, at the same time addressing mutual accountability and strengthening harmonization and alignment.

8. The present report provides an overview of the programmatic work of UNFPA related to maternal and newborn care, investing in family planning and midwifery, enhancing reproductive health commodity security, preventing and treating obstetric fistula, abandoning the practice of female genital mutilation/cutting, eliminating gender-based violence, addressing adolescent pregnancy and child marriage, preventing mother-to-child transmission of HIV, comprehensive condom programming to prevent unintended pregnancy and HIV infection and providing reproductive health services in emergency situations.

II. Maternal health and family planning

9. More than 500,000 women die in childbirth every year, 99 per cent of them in developing countries.[2] Africa suffers from the highest maternal mortality ratio at 820 maternal deaths per 100,000 live births, followed by Asia (320), Oceania (180) and Latin America and the Caribbean (130) as compared to a maternal mortality ratio of 13 in Europe and 10 in North America (see figure 1). In 2005, 14 countries had maternal mortality ratios of at least 1,000, of which 13 (excluding Afghanistan) were in sub-Saharan Africa.[3]

10. Maternal mortality rates reflect the vast disparities between developed and the less and least developed countries. Millennium Development Goal 5 calls for, inter alia, a reduction in the maternal mortality ratio by three quarters between 1990 and 2015. In order to reach this target, the global maternal mortality ratio would have to be reduced by an average of 5.5 per cent a year between 1990 and 2015. However, the reduction between 1990 and 2005 was only 0.4 per cent a year.[4] Given this rate

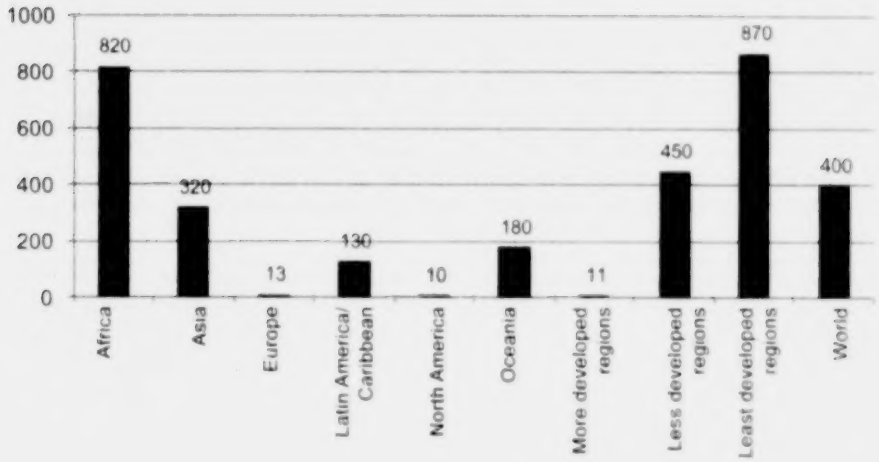
[2] World Health Organization (2009). *Women and Health*.

[3] World Health Organization (2007). *Maternal Mortality in 2005. Estimates developed by WHO, UNICEF, UNFPA and The World Bank*, annex 3.

[4] Ibid., appendix 14.

of progress, the world will remain far behind the Millennium Development Goal target for maternal mortality ratio reduction in 2015.

Figure I
Estimates of maternal mortality ratio by United Nations Population Division regions, 2005



Source: World Health Organization (WHO, 2007). *Maternal Mortality in 2005: Estimates developed by WHO, UNICEF, UNFPA and The World Bank.*

11. Most maternal and newborn deaths can be prevented if women have access to family planning services and receive the appropriate care during pregnancy and childbirth. The most cost-effective interventions to reduce maternal mortality are family planning, skilled birth attendants during delivery and emergency obstetric care and, more generally, the empowerment of women and the elimination of gender inequalities which prevent women from making their own decisions and from having the support of their partners.

12. Providing women with both family planning and maternal and newborn health services would result in a decline in maternal deaths by an estimated 70 per cent compared to a decline of 57 per cent if developing countries invested in maternal and newborn health care alone. If contraceptive needs were adequately addressed, the reduction in unintended pregnancies would result in considerable declines in abortion and related health complications. It is estimated that the number of women requiring medical care for complications from unsafe abortion would decline by 73 per cent. It is also estimated that meeting the need for both family planning and maternal and newborn health services would result in a reduction by more than 60 per cent of healthy years of life lost owing to disability and premature death among women and newborns as measured in disability-adjusted life years (DALYS). More women would survive haemorrhage and infection, fewer would suffer from fistula, infertility and other pregnancy/childbirth-related health problems, and newborns would have a better chance of surviving asphyxia, low birth weight and infection.[1]

13. At the core of the UNFPA mandate is ensuring that every pregnancy is wanted and every birth is safe. UNFPA includes maternal health as part of a package of interventions in the area of sexual and reproductive health and assists countries in the development of needs assessments to ensure that health plans are Millennium Development Goal-driven and performance-based towards universal access to reproductive health. As part of the effort to fulfil its mandate, UNFPA initiated a Maternal Health Thematic Fund, which provides additional support to priority countries to improve the health of women and newborns. For example, with the Maternal Health Thematic Fund seed fund, UNFPA provided support to Malawi and Ethiopia to launch a national Campaign for Accelerated Reduction of Maternal Mortality. In partnership with UNICEF, Columbia University and the Ministries of Health, emergency obstetric and neonatal care needs assessments were carried out in Haiti and Ethiopia and maternity services at the district level are being strengthened. That cooperation seeks to develop a network of regional institutions and a roster of experts to build national and regional capacity in emergency obstetric and newborn care.

14. Ensuring coverage of emergency obstetric care and quality delivery care is critical for saving the lives of mothers and newborns. In Côte d'Ivoire, for example, the Ministry of Health, with assistance from UNFPA, instituted a maternal and perinatal death review system, which allows health facilities to document, analyse, and address causes of maternal death to improve care and reduce future deaths. The next step will be to establish routine maternal audits in comprehensive emergency obstetric care and to record maternal deaths.

15. Removing financial barriers to universal access to reproductive health is essential to ensuring that the poorest, who are the most affected, have increased access to delivery care. Madagascar received technical assistance from UNFPA and additional resources to launch its exemptions fees policy for caesarean sections, and in Ghana, obstetric care is now included in the National Health Insurance Scheme.

16. The lack of a qualified health workforce, especially a strong cadre of midwives, is an impediment to acceleration of progress towards the achievement of Millennium Development Goal 5. To help address this issue, UNFPA launched an Investing in Midwives Programme in 2008 in collaboration with the International Confederation of Midwives. The programme, which is under way in 15 countries, mainly in sub-Saharan Africa, addresses all three pillars of safe motherhood: family planning, skilled attendance at all births and emergency obstetric care. The programme seeks to achieve its goals by building a critical mass of experienced midwifery advisers who work at the national level and collaborate with all national stakeholders in strengthening midwifery.

17. Since the programme's inception, countries have conducted reviews and needs assessments with regard to standards of midwifery training, legislative and regulatory environment to allow midwives to deliver life-saving interventions, and assessment of the status of professional midwifery associations. For example, in Benin, national supervisory guidelines on maternity services at peripheral levels were established. The Ministry of Health in Djibouti adopted a law that equates a midwifery certificate with a first-level university degree. Cambodia has a new Midwifery Council and will be drafting a midwifery education, services and regulations framework. In Côte d'Ivoire, the programme is supporting a project for strengthening obstetric capacities of midwife graduates before deployment. Ethiopia

conducted an assessment of midwifery training institutions and equipped them with training materials and supplies. Ghana also conducted an assessment of all midwifery schools and discussions are under way to develop a code of ethics for midwives. A midwifery census in Guyana will determine the baseline number of midwife graduates; the country is also providing support to the General Nursing Council to improve regulations.

18. Family planning is a key factor in achieving Millennium Development Goal 5. It is one of the most cost-effective strategies to reduce maternal mortality and ensure a continuum of maternal health care as part of reproductive health and the right to health. Despite the critical need for family planning, funding has virtually stagnated since 2001.[5] Family planning is usually omitted in the planning, budgeting and implementing of maternal health programmes.

19. In 2008, UNFPA continued efforts to ensure the right of all people to decide the number and spacing of the birth of their children. UNFPA works with Governments, civil society and United Nations partners to forecast needs, provide and coordinate the distribution of contraceptives and maternal health supplies and build logistical capacities of countries. For example, efforts are under way in Benin to re-position family planning in the health system. Madagascar adopted a policy of long-term methods for family planning free of charge, the provision of free family planning services in all health facilities, an integration of family planning at all HIV voluntary testing and counselling centres, the expansion of contraceptive method choices and an improved monitoring system. In Haiti, family planning protocols are being revised and supply delivery is being scaled up, with a focus on communities where the demand is greatest.

20. Commodities, such as contraceptives and medicines for emergency obstetric care, help improve maternal health by preventing unintended pregnancies, facilitating reproductive health and averting the spread of HIV. UNFPA is the lead United Nations agency working with the private and public sectors to ensure that reproductive health commodities are accessible and affordable. Continued funding from the Global Programme to Enhance Reproductive Health Commodity Security enabled the Fund to expand its support to Governments to mainstream Reproductive Health Commodity Security into national health policies, programmes, budgets and plans. As of 2008, 80 countries had national budget lines for contraceptives and other reproductive health supplies.

21. To meet urgent reproductive health commodity needs and avoid supply "stock outs" in 2008, UNFPA provided technical assistance for logistics and information systems and about $20 million of reproductive health commodities to some 60 countries. These commodities included male and female condoms, other contraceptives and drugs to protect maternal health. UNFPA used its "RHCS Dashboard" tool to monitor global progress towards Reproductive Health Commodity Security, giving countries scores that measure their overall progress in key categories.

22. International coordination to reach Millennium Development Goal 5 gained in strength and momentum. The H4 partnership — WHO, UNFPA, UNICEF and the

[5] United Nations Population Fund (2009). *Financial Resource Flows for Population Activities in 2007*, and United Nations Population Fund (2008). *Donor Support for Contraceptives and Condoms for STI/HIV Prevention 2007*.

World Bank — contributes to a global effort to accelerate progress in maternal and newborn survival, issuing a Joint Statement on Maternal and Newborn Health in 2008, followed by the development of a Joint Country Support Plan for Accelerated Implementation of Maternal and Newborn Continuum of Care. The H4 is intensifying in-country work beginning in 25 priority countries with a view to provide enhanced support over the next five years to all 60 countries with high maternal mortality.

23. In the framework of the Partnership for Maternal, Newborn and Child Health, the International Health Partnership and other related initiatives, UNFPA and its partners promote universal coverage of essential interventions for reproductive health while advocating for harmonized approaches in support of nationally led efforts. UNFPA has been active in the High-Level Task Force on Innovative Financing for Health Systems, which assessed the challenges and financial requirements for scaling up to achieve the health-related Millennium Development Goals, including Millennium Development Goal 5.

III. Obstetric fistula

24. Obstetric fistula is a devastating childbirth injury that leaves women incontinent, ashamed and often isolated from their communities. It is a stark example of unacceptably high levels of maternal death and disability. The condition disproportionately affects impoverished women and girls living in rural communities in the least developed countries. Obstetric fistula is almost entirely preventable through access to quality maternal health care. Bringing an end to obstetric fistula requires addressing underlying social and economic inequities, including gender inequality, that hinder women from fulfilling their reproductive rights.

25. Prolonged, obstructed labour causes the vast majority of obstetric fistulas worldwide. Globally, obstructed labour occurs in nearly 5 per cent of deliveries. While robust population-based measurements are lacking, it is generally accepted that at least 2 million women, and as many as 3.5 million, are suffering from obstetric fistula.[6] WHO estimates that approximately 73,000 new cases occur annually,[7] which may be an underestimate as it is based on facility data and the majority of women likely never reach a hospital.

26. To address the need for data, a number of countries[8] included modules on obstetric fistula in their Demographic and Health Surveys. Modules varied between countries, but contained questions regarding obstetric fistula knowledge and experience of symptoms.[9] Figure 2 below provides estimated lifetime prevalence of

[6] L. L. Wall, "Obstetric vesicovaginal fistula as an international public-health problem", *The Lancet*, vol. 368, Issue 9542 (30 September 2006), pp. 1201-1209.

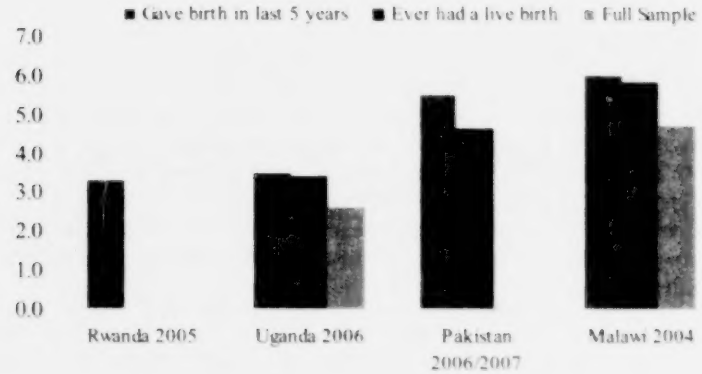
[7] C. AbouZahr, "Global burden of maternal death and disability", *British Medical Bulletin*, vol. 67, No. 1 (December 2003).

[8] The Democratic Republic of the Congo, Ethiopia, Malawi, Mali, the Niger, Nigeria, Pakistan, Rwanda and Uganda.

[9] Central Statistical Agency, Addis Ababa and ORC Macro, Maryland, United States of America, *Ethiopia Demographic and Health Survey 2005*; Salif Samaké et al., *Mali: Enquête Démographique et de Santé (EDSM-IV) 2006*.

fistula symptoms for all women who reported ever having experienced symptoms described by the Demographic and Health Surveys question.

Figure 2
Estimated lifetime prevalence of fistula symptoms among selected samples of women in countries with latest available Demographic and Health Surveys data



Source: Compiled by Population and Development Branch, UNFPA. National Demographic and Health Surveys 2005/2006. USAID (2008) DHS Analytical Studies. Incontinence data from Demographic and Health Surveys: Comparative analysis of a proxy measurement of vaginal fistula and recommendations for future population-based data collection.

27. Among the countries for which data are available, Pakistan and Malawi have a fistula prevalence among women who had a live birth in the past five years between 5 and 6 per cent. The rates for Rwanda and Uganda are between 3 and 4 per cent. Ethiopia has a prevalence rate of 1.0 per cent among women who have ever had a live birth. Lifetime prevalence in Mali, the Niger, the Democratic Republic of the Congo, and Nigeria would be significantly lower, under 1 per cent. Owing to the sensitive nature of the subject and problems with recalling events that may have happened in the distant past, it is likely that these figures underestimate the real extent of fistula prevalence.

28. In 2003, UNFPA and partners launched the global Campaign to End Fistula, which includes interventions to prevent fistula, treat affected women and help women who have undergone treatment return to full and productive lives. The ultimate goal of the Campaign is to make fistula as rare in developing countries as it is in the industrialized world by 2015. The Campaign is currently active in more than 45 countries in the Africa, Asia and the Arab States regions. An international partnership, the Obstetric Fistula Working Group, was created to ensure global coordination of efforts to eliminate obstetric fistula. The Campaign strives to build political commitment and broad support for achieving the international goals related

to maternal and newborn health by highlighting the human consequences of failure to act.

29. The results to date are encouraging: at least 38 countries have completed a situation analysis of fistula prevention and treatment; more than 25 countries have integrated the issue of fistula into relevant national policies and plans; at least eight countries have developed national fistula-elimination policies; more than 12,000 women have received fistula treatment and care with support from UNFPA; thousands of health personnel have received training in fistula management and care and, at the close of 2008, 31 countries included the issue of fistula in their country programmes.

30. As part of national efforts to increase access to fistula care, many countries are working to reduce the cost of prevention and treatment services. In Ghana, fistula treatment will now be free as part of the National Health Insurance Scheme. In Guinea-Bissau, support was provided to community-based health insurance programmes. In Mauritania, UNFPA supported special emergency obstetric funds in districts with high rates of maternal mortality and morbidity. In Pakistan, a number of regional centres now provide free fistula treatment, and outreach campaigns were conducted throughout the country to make treatment services more accessible for women living in remote areas.

31. In 2008, the United Nations Development Programme granted an award of excellence to the Campaign to End Fistula for championing South-South cooperation. As an example of efforts in this area, in Bangladesh, a 2008 regional fistula capacity-building workshop brought together teams of surgeons, anaesthesiologists and nurses from Timor-Leste, Nepal and Pakistan. Complex fistula surgeries were performed allowing for technical exchange. The Campaign will continue to build upon these experiences and work to facilitate South-South opportunities.

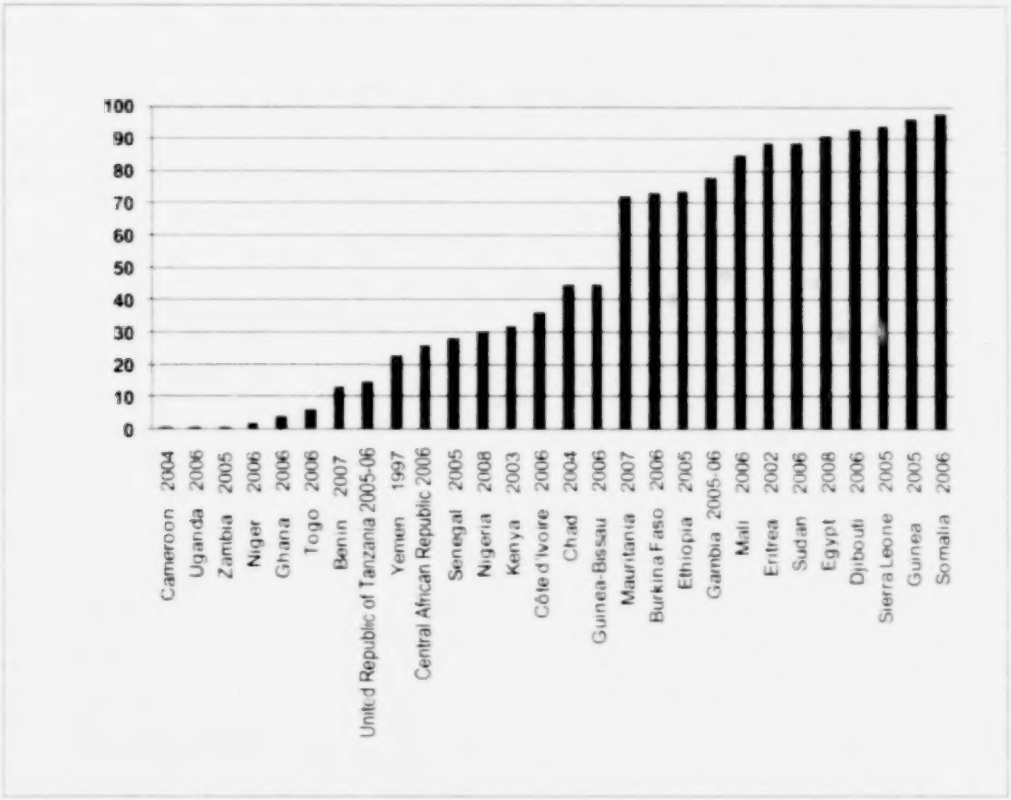
IV. Female genital mutilation/cutting

32. According to estimates by WHO, between 100 and 140 million women and girls in the world have experienced some form of female genital mutilation/cutting. It is estimated that approximately 3 million girls and women in Africa are subject to it each year.[10]

33. Demographic and Health Survey and Multiple Indicator Cluster Survey data on female genital mutilation/cutting are available for 26 countries. The rates vary significantly from country to country, from as low as 1 per cent in Cameroon to as high as 98 per cent in Somalia. Geographic patterns vary: north-eastern African countries (Djibouti, Egypt, Eritrea, Ethiopia, Somalia and the Sudan) have rates ranging from 74 to 98 per cent, while rates in East Africa (Kenya and the United Republic of Tanzania) are significantly lower, ranging from 15 to 32 per cent. Most countries for which data are available show a decrease in the prevalence of female genital mutilation/cutting over time. However, the incidence continues to remain high (see figure 3).

[10] World Health Organization. http://www.who.int/reproductivehealth/topics.

Figure 3
Female genital mutilation/cutting prevalence among women aged 15-49 years, 2000-2008



Source: Compiled by Population and Development Branch, UNFPA. Data for Eritrea 1995, Kenya 1998 and Nigeria 2008 from Demographic and Health Surveys 2008 and UNICEF ChildInfo (2009).

34. The UNFPA-UNICEF Joint Programme and Trust Fund on Female Genital Mutilation and Cutting was established to support the development and implementation of policies and programmes and to reinforce the efforts of national partners, development partners and civil society organizations to accelerate the abandonment of female genital mutilation/cutting. The programme aims to contribute to a 40 per cent reduction of the practice among girls aged 0-15 years in 17 countries in Africa, with at least one country declared free of female genital mutilation/cutting within a period of five years (2008-2012). Currently, 17 countries in Africa[11] are implementing the programme, which also provides technical support to other countries, including Colombia and Indonesia.

[11] Burkina Faso, Djibouti, Egypt, Eritrea, Ethiopia, the Gambia, Ghana, Guinea, Guinea-Bissau, Kenya, Mali, Mauritania, Senegal, Somalia, the Sudan, the United Republic of Tanzania and Uganda.

35. Data are available for some countries where the programme is implemented. Burkina Faso, Egypt, Eritrea, Ethiopia, Ghana, Guinea, Kenya, Mali and the United Republic of Tanzania all show a decrease in their national prevalence of female genital mutilation/cutting among girls and women.

36. In 2009, following the launch of the Inter-agency Statement on Eliminating Female Genital Mutilation, signed by 10 United Nations agencies, a Platform for Action of the Donors Working Group on Female Genital Mutilation/Cutting was published in English, French, Arabic and Portuguese and served to widen the endorsement of the common programmatic approach championed by the UNFPA-UNICEF Joint Programme to include Governments, intergovernmental institutions and foundations.

37. The Joint Programme works closely with other United Nations agencies when gaps are identified. The new trend of medicalization of female genital mutilation/cutting by doctors and other trained health-care providers in clinical settings who are performing the procedure is also being addressed. An interregional initiative in sub-Saharan African and Arab countries in collaboration with WHO was put in place to ensure the support of the medical professions in the public abandonment of female genital mutilation/cutting.

38. The Joint Programme has built the capacity of over 34,929 community members in 190 communities, including 1,125 youths in Egypt and 2,400 community members and youth leaders in Kenya to support the abandonment of female genital mutilation/cutting. In 2009, over 500 villages in Senegal publicly declared female genital mutilation/cutting abandonment. This takes the movement of abandonment to over 4,000 communities out of the 5,000 practising female genital mutilation/cutting in Senegal. The programme supported the training of religious leaders concerning female genital mutilation/cutting and religion, and successfully recruited high-level leaders in Djibouti and the Sudan. In several countries, the programme facilitated community dialogue sessions. A lobby group of Muslim scholars was established in Kenya from among communities that do not practise female genital mutilation/cutting to hold dialogue forums with other Muslim scholars in communities that practise female genital mutilation/cutting, using religious arguments to separate female genital mutilation/cutting from Islam to create a national position of Muslim scholars against the practice.

39. In Ethiopia, more than 2,000 uncircumcised girls have been registered in the Afar region, an unprecedented success in the history of that region of the country. In the Gambia, 24 communities from two districts involved in the community empowerment programmes for approximately two years publicly declared the abandonment of female genital mutilation/cutting and child/forced marriage, the first inter-community public declaration in the Gambia. In the Sudan, over 200 women known as "The Saleema Mothers", who vowed publicly not to excise their daughters, were conferred awards by the First Lady. In fostering partnerships at all levels, the programme supported the creation and enhancement of networks of parliamentarians, the media, traditional communicators, animators, women lawyers, medical associations, the network of public transportation drivers, and grandmothers and midwives.

40. At the policy level, through the support of the Joint Programme, the Egyptian Parliament included female genital mutilation/cutting as a punishable offence in the penal code and amended the child law to require the creation of decentralized child

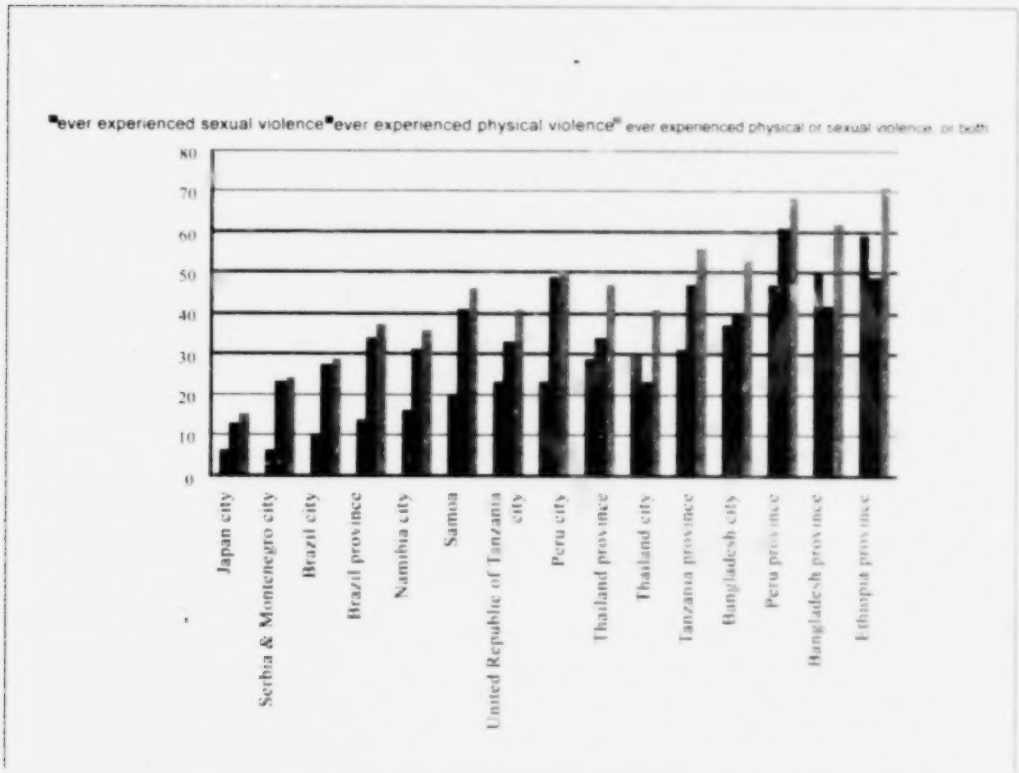
protection committees at the governorate and district levels. Nationwide, 28 Child Protection Committees have been formed, tasked with designing child protection policies and monitoring policy implementation in Egypt. In Kenya and the Sudan, the National Child's Act was revised to include female genital mutilation/cutting as a criminal offence.

V. Gender-based violence

41. Given the right opportunities, women can greatly improve their health and well-being and that of their families and communities. However, discrimination and violence against women and girls and poor reproductive health in many countries serve to minimize women's potential contributions.

42. Gender-based violence is a widespread phenomenon that knows no boundaries and has serious public health implications. It can take many forms, from physical abuse, to sexual harassment and abuse, abuse by persons in authority such as teachers, employers or police officers, trafficking and exploitation for forced labour or sex, traditional practices such as forced or child marriages and dowry-related violence. Abused women have higher rates of unintended pregnancies, abortions, adverse pregnancy outcomes, sexually transmitted diseases, including HIV, and mental disorders, including depression, anxiety, and sleep and eating disorders. Gender-based violence can lead to serious injury, disability and even death.[2] Since most violence against women is committed by intimate male partners, gender-based violence is extremely difficult to measure because many women are afraid to come forward as victims. Figure 4 shows a wide variation in prevalence of lifetime physical violence and sexual abuse perpetrated by an intimate partner across different settings.

Figure 4
Prevalence of lifetime physical violence and sexual violence by an intimate partner, among ever-partnered women, 2005



Source: Compiled by Population and Development Branch, UNFPA. WHO (2005) Multi-country Study on Women's Health and Domestic Violence Against Women. Summary report.

Note: City refers to the capital or a large city and province refers to a region, usually containing both urban and rural populations. A single rural setting was used in Japan, Namibia, and Serbia and Montenegro. In Samoa, the entire country was sampled.

43. As the lead United Nations agency on sexual and reproductive health, UNFPA has a strategic entry point to address gender-based violence, given the intrinsic linkages between sexual and reproductive health and gender-based violence. Addressing gender-based violence through sexual and reproductive health services, including HIV/AIDS programmes, that UNFPA supports is at the centre of the Fund's strategy on gender-based violence. The multi-pronged and multisectoral approach includes support for strengthening the role of the health sector in addressing gender-based violence, focusing on both supply- and demand-side interventions, addressing violence in the home and sexual abuse in childhood and adolescence, addressing gender-based violence in conflict and post-conflict situations, and focusing on the most vulnerable and marginalized. In Haiti, for example, UNFPA pursued an extended partnership with the Ministry of Women's Affairs and key civil society actors to consider inclusion of the reproductive rights

agenda, particularly those of marginalized women and adolescent girls, sex workers, women living with HIV and women living with disabilities. In Liberia, UNFPA worked with the criminal justice system to improve its response to gender-based violence by establishing a special court for the prosecution of rape cases and by increasing the capacity of legal professionals. UNFPA Burundi supported awareness-raising on the links between sexual violence and HIV, with a focus on youth, faith-based groups and demobilized military personnel.

44. One of the key starting points to strengthen country-level processes and accountability mechanisms on gender-based violence as it relates to macro-level sexual and reproductive health issues is at the policy and legal levels. UNFPA has been a key partner in many countries in supporting the drafting of national laws, implementation and public awareness-raising efforts in this regard. The Fund is engaged at the national level in advocacy and technical assistance for the development and monitoring of leading policy and funding frameworks, including poverty reduction strategies, other Millennium Development Goal follow-up plans, sector-wide approaches, and national HIV/AIDS plans. In 2006, for example, the Venezuelan National Assembly passed a new law on violence against women that recognizes "obstetric violence" and "gynaecological violence" as forms of violence against women, a process supported by UNFPA. The Fund has helped to spearhead national campaigns on violence against women including, in recent years, in Latvia, Morocco, Timor-Leste and Turkey. In Burundi, a campaign on sexual violence was initiated. In Belarus, a United Nations campaign with the motto "Domestic violence should not be a part of your life" was begun. In Zimbabwe, a multimedia campaign was launched to garner support for the Domestic Violence Bill.

45. UNFPA is an active member of the Secretary-General's campaign to end violence against women, UNiTE. The Fund is currently Co-Chair of the United Nations Inter-Agency Task Force on follow-up to the 2006 Secretary-General's In-Depth Study on All Forms of Violence against Women. The agency supports the Coordinator of the Task Force and devotes resources to joint programming efforts in 10 pilot countries.[12] It also has an ongoing partnership with UNIFEM, the lead global "champion" on the issue. UNFPA is a lead member of the United Nations Trust Fund on Violence against Women managed by UNIFEM. At the country level, UNFPA serves as Chair of the United Nations Gender Theme Groups, and acts as lead or co-lead on gender-based violence coordination bodies, especially in humanitarian contexts. In the context of delivering as one, UNFPA and its sister agencies address gender-based violence in Viet Nam, including assisting in the implementation, monitoring and evaluation of the Law on Gender Equality and the Law on Domestic Violence Prevention and Control.

46. To ensure reliable and comparable data on violence against women and girls, UNFPA supports a number of key interventions, including developing quantitative and qualitative indicators on gender-based violence and supporting countries in data collection and analysis; Demographic and Health Survey modules on domestic violence; evidence-based sociocultural research; collection of service-based data gathered from public and private agencies that come into contact with victims of

[12] For more information on the work of the United Nations Task Force on Violence against Women, which was established by the Inter-Agency Network on Women and Gender Equality, see www.un.org/womenwatch/ianwge/taskforces.htm.

violence; developing models and projections for decision makers on the costs of inaction; and filling key research gaps, such as abuse during pregnancy.

47. To strengthen demand-side interventions and ensure that services are used by those most in need, UNFPA supports national campaigns on violence against women, training journalists and integrating gender issues and human rights education into curricula of police academies. UNFPA works to strengthen the health sector's role in addressing gender-based violence, raising awareness of reproductive rights violations in the health sector as a form of gender-based violence, instituting health sector policies and human rights mechanisms for redress, developing capacities and supporting the institutionalization of reporting systems with the health and other social service sectors, and institutionalization of training curricula on gender-based violence for health professionals. In Honduras, for example, UNFPA supported the institutionalization of police training on violence against women, claimed as the second greatest achievement of the President's Administration in 2004.

48. UNFPA works to mobilize communities to foster a culture of zero tolerance on violence against women and girls, including working with elders and opinion leaders, and to institutionalize norms and training programmes for strengthened women's human rights protections and legal enforcement, with emphasis on the judiciary and the police, while seeking to draw linkages between legal and security services and the health sector. The Fund supports the establishment of partnerships and programme linkages to promote women's economic opportunities and autonomy, including supporting women escaping abusive situations, such as through microfinance and skills training. In Mauritania, midwives alarmed about sexual violence in their communities began mobilizing against rape. They were later joined by imams. Such mobilization was undertaken with UNFPA support and led to the first national statistics on the issue and the establishment of the first centre for survivors.

49. Promoting gender equality and eliminating violence against women and girls require a concerted effort to actively engage men and boys as partners and agents for change. UNFPA incorporates tailored interventions and messages for men and boys on gender equality and zero tolerance for violence against women in its sexual and reproductive health programmes, including those related to HIV prevention.

50. UNFPA continues to build and strengthen partnerships with faith-based networks and works with religious leaders and inter-faith networks to help eliminate violence against women. It offers capacity development opportunities to religious leaders and inter-faith networks on gender-based violence concepts and strategies to assist them to effectively reach their constituencies and to strengthen their advocacy against violence against women and their participation in service delivery programmes.

VI. Adolescent pregnancy and child marriage

51. An estimated 14 million adolescents aged 15-19 in developing countries gave birth in 2008. Pregnancy rates among adolescents are high in many countries, particularly among the poor. High fertility rates among this age group are associated with higher maternal mortality due to complications from pregnancy and delivery, as well as from unsafe abortions. In the developing world, females aged 15-19

account for 14 per cent of all unsafe abortions.[12] Millennium Development Goal 5 includes an indicator measuring the annual number of births to women aged 15-19 years. Girls under the age of 17, particularly those aged 15 years and under, are more at risk of maternal mortality.

52. High rates of early childbearing in many developing countries result primarily from the practice of child marriage.[13] Worldwide, more than 51 million adolescent girls are married, and in the next decade, 100 million more will be married by their eighteenth birthday should present trends continue.[14] This is despite the fact that child marriage is a violation of the Convention on the Rights of the Child, and that child marriage is against the law in many countries.

53. In addition to being a rights violation, child marriage places adolescent girls at major health risks. Child brides typically have higher levels of unprotected sexual relations (often forced or coerced) and intense pressure to become pregnant. They are typically married to older, more sexually experienced spouses, making them at risk of HIV infection as well. They become the youngest first-time mothers, with little knowledge, health care, and support, often giving birth without a skilled attendant.

54. UNFPA work on adolescent pregnancy and child marriage is multifaceted and includes programmes for reaching marginalized girls, increasing the age at marriage, keeping girls in school, building their life skills, and providing access to contraceptives and other sexual and reproductive health services, including HIV prevention.

55. As a major component of the UNFPA work to uphold the rights of young people, especially marginalized adolescent girls, UNFPA is actively working to counteract child marriage. UNFPA advocacy efforts include raising awareness about child marriage and working with Governments to enact laws against the practice. UNFPA also works closely with communities and religious leaders to find ways to discourage and eventually eliminate child marriage, such as promoting schooling and building leadership skills for young women. In 2009, the General Assembly adopted resolution 64/145 on the girl child, focusing on child marriage and calling on States to take measures to address the root causes of child and forced marriages, to raise awareness of the negative aspects of such practices and to strengthen legislation and policies to protect the rights of the child, especially the girl child.

56. UNFPA country offices support innovative programmes that address adolescent pregnancy and child marriage. In Ethiopia's Amhara region, where rates of child marriage are among the highest in the world, the UNFPA-supported Berhane Hewan programme follows a conditional cash transfer model by encouraging families to allow their girls to participate in the programme rather than marrying them off. Both married and unmarried girls in the programme develop functional literacy and life skills, and receive reproductive health education.

57. In Guatemala, the UNFPA-supported Opening Opportunities programme works with marginalized girls at risk of pregnancy and child marriage to provide them with leadership, entrepreneurial and life skills, as well as information about gender

[12] United Nations Population Fund (2007), *Giving Girls Today and Tomorrow: Breaking the Cycle of Adolescent Pregnancy*.

[13] United Nations Population Fund (2005), *State of World Population: The Promise of Equality: Gender Equity, Reproductive Health and the Millennium Development Goals*.

equality and reproductive health. These models have shown that preventing child marriage (and the associated risks of maternal death and disabilities) requires providing girls with the opportunities, information and skills to imagine an alternative to early pregnancy, childbearing and maternal deaths and disabilities.

58. At the global level, UNFPA has forged a unique partnership with UNICEF, ILO, UNESCO, UNIFEM and WHO to address the multifaceted issues facing adolescent girls, including their education, health, livelihoods and other development concerns. In 2007, the agencies established the United Nations Inter-agency Task Force on Adolescent Girls, co-chaired by UNFPA and UNICEF. The Task Force supports collaboration at the country level — with government ministries, non-governmental organizations, and women's and girls' networks — to identify marginalized adolescent girls at risk of multiple rights violations and to implement programmes aimed at ending their marginalization and enabling adolescent girls to claim their full rights and access to social services, particularly education, health care, employment and human development.

VII. HIV/AIDS prevention

59. HIV is currently the leading cause of mortality in women of reproductive age, with HIV-related maternal mortality rates in sub-Saharan Africa, increasing and surpassing other causes.[3] The high prevalence of HIV in childbearing women is the main cause of child infections, as more than 90 per cent of infant and young child infections occur through mother-to-child transmission, either during pregnancy, around the time of birth, or through breastfeeding. With 370,000 new child infections every year[15] (17 per cent of all new infections[16]), there are 2 million children under the age of 15 living with HIV (an increase from 1.6 million in 2001[16]), resulting in 31 child deaths every hour.[15] Children born to mothers living with advanced stages of HIV are more likely to die irrespective of their own HIV infection status.

Preventing mother-to-child transmission

60. As co-sponsor of UNAIDS, UNFPA leads various initiatives to reduce the spread of HIV and works with partners to support the scaling up of HIV prevention programmes. Among the activities is a comprehensive approach to the prevention of mother-to-child transmission (PMTCT), which includes HIV prevention measures and a continuum of appropriate care for mothers and their children. The approach has four programme components: (a) primary prevention of HIV among women of childbearing age; (b) prevention of unintended pregnancies among women living with HIV; (c) prevention of HIV transmission from a woman living with HIV to her infant (perinatal transmission); and (d) providing appropriate treatment, care and support to women living with HIV and their children and families.

61. The Inter-agency Task Team on Prevention of HIV Infection in Pregnant Women, Mothers and their Children, of which UNFPA is a main partner, is providing support to countries for comprehensive PMTCT, most recently articulating joint strategies through the 2007 Guidance on Global Scale-up of the

[15] UNAIDS, *2008 Report on the global AIDS epidemic* (data from 2007).

[16] *2008 UNAIDS Annual Report: Towards Universal Access* (data from 2007).

Prevention of Mother-to-Child Transmission of HIV, and operationalizing the 2009 UNAIDS Outcome Framework in the priority area of PMTCT.

62. A number of UNFPA country offices carried out activities to support the scaling up of comprehensive PMTCT, although it is still under-programmed in the majority of regions. For example, in Burundi, UNFPA provided support to the Government and civil society in order to promote advocacy and support integration of HIV activities and other reproductive health services, including antenatal care, skilled birth attendance and family planning services for couples and HIV-positive women who do not wish to become pregnant. In Tajikistan, UNFPA supported training of trainers at regional reproductive health centres on integration of PMTCT into effective perinatal care. In Thailand, UNFPA introduced a development model to strengthen PMTCT by encouraging male participation to help prevent HIV infection among pregnant women.

63. In Colombia, UNFPA is supporting a strategy that seeks to increase the voluntary testing of and attention to HIV in the package of reproductive health services having a comprehensive approach to reproductive health. In Kenya, UNFPA, in collaboration with WHO and UNICEF, continues to support the Ministry of Health to strengthen the PMTCT programme in the country. UNFPA has trained a number of counselling staff in family planning as a way of strengthening the provision of these services. In Nepal, UNFPA supported the Government in the development of a national package for linking PMTCT of HIV and sexual and reproductive health services. In Turkmenistan, UNFPA conducted training of trainers on HIV/AIDS counselling of pregnant women for obstetrics/gynaecology and staff of HIV/AIDS centres.

Comprehensive condom programming

64. As part of its strategic response to HIV, UNFPA continues to lead the Global Condom Initiative, which includes comprehensive male and female condom programming for the prevention of STIs, including HIV, and unintended pregnancy. The Initiative is ongoing in 55 countries. For the third consecutive year, overall access to female condoms has dramatically increased and reached a record number of 33 million in 2008. For example, in 2008, despite the difficult economic and political situation in Zimbabwe, the country managed to have the largest female condom distribution per capita, increasing distribution from 2.2 million (2006) to 5.2 million (2008). Other countries have also doubled or tripled access to female condoms for women and girls. Partnership with several agencies helped maximize access to male and female condoms through public, civil society, social marketing and private sectors. Efforts were made to reach populations in remote and rural areas with targeted distribution programmes for vulnerable and marginalized populations including groups most at risk.

65. UNFPA works to strengthen human and institutional capacity of users, service providers and institutions in the area of behaviour change, condom awareness, condom destigmatization, and creative promotion and communication strategies on condoms. In about 50 per cent of the Global Condom Initiative countries, trainers have been equipped with skills to educate populations and users about correct use of male and female condoms. For example, in the Central African Republic, health workers were trained in family planning, including female condom use. Kenya supported the establishment of a condom quality assurance National Quality Control

Laboratory of the Ministry of Health, including the training of staff on the use of condom-testing equipment. Malawi supported the training of hair salon owners in female condom use and disposal. Swaziland supported a national multimedia campaign on condom promotion targeting 15-24 year olds. In Zimbabwe, HIV focal persons from tertiary educational institutions were trained in female condom promotion and safer sex negotiation.

66. Twenty countries drafted national condom strategies and are working to develop a five-year costed operational plan, including a division of labour among implementing partners. In West Africa, UNFPA signed a memorandum of understanding with the Population Council working with and using the expertise of the Council to support reproductive health programmes.

VIII. Reproductive health in emergencies

67. Complex conflicts and acute or chronic natural disasters exacerbate poverty, diminish the access of affected populations to basic information and social services, undermine human rights and security, and increase vulnerability to gender violence and exploitation. Severe economic dislocation and extended political crises also have implications for meeting basic human needs, of which reproductive health needs are notable examples.

68. A decade of UNFPA work in crisis and recovery has followed a set of guiding principles: (a) the right to reproductive health is universal and applies to women, men and adolescents everywhere, including during humanitarian crises and recovery; (b) accurate demographic and health data are the cornerstone of effective humanitarian response, national reconstruction, emergency preparedness and conflict prevention; and (c) attention to gender aspects is critical for effective humanitarian response and reconstruction.

69. UNFPA focuses on supporting capacity development and on building commitment for integrating the International Conference on Population and Development Programme of Action into emergency preparedness, humanitarian crisis response and transition and recovery processes at the national level. The strategy takes into account the ongoing United Nations humanitarian reform and its implications for UNFPA operations and acknowledges the Fund's central role in promoting reproductive health and rights and gender equality in humanitarian situations. The institutional strategy reflects the UNFPA niche in reproductive health and in the area of data in emergency and humanitarian situations.

70. UNFPA also carried out intensive and effective advocacy on International Conference on Population and Development issues within the Inter-Agency Standing Committee, Inter-agency Working Group on Reproductive Health in Crisis Situations, United Nations Development Group/Executive Committee on Humanitarian Assistance and other bodies, leading to an increased awareness and acceptance of the need to address reproductive health and the differing needs and vulnerabilities of women and girls in emergencies, refugee situations and post-crisis transition. An example of the success of advocacy efforts is the fact that the Conference Programme of Action is now integrated into humanitarian assistance funding frameworks such as the Central Emergency Response Fund, the Consolidated Appeals Process (CAP), Flash and the Humanitarian Emergency Response Fund.

71. UNFPA also works with partners leading the revision of the Inter-agency Field Manual in Reproductive Health in Crisis Settings, targeting reproductive health coordinators, clinicians and care providers in the field, providing them with the latest information available to design, implement and coordinate reproductive health programme components in the field. An Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings has been produced by Save the Children and UNFPA as a companion to the field manual.

72. UNFPA contributed significantly to promoting health and reducing morbidity and mortality before, during and after crises, notably promoting reproductive health and reducing reproductive health-related morbidity and mortality among women, men, girls and boys. Through implementation of the Minimum Initial Service Package in the onset of an emergency situation, UNFPA seeks to: (a) prevent excess maternal and neonatal mortality and morbidity; (b) prevent and manage the consequences of sexual violence; (c) reduce HIV transmission; (d) plan for comprehensive reproductive health services in the early days and weeks of an emergency; and (e) ensure coordination of implementation and among various actors. To effectively implement the Service Package, UNFPA provides reproductive health kits containing medical supplies, drugs and equipment that can be shipped within 72 hours anywhere in the world to respond to the needs of populations caught in emergencies.

73. In 2008, UNFPA provided direct and intensive field support to about 60 country offices requiring assistance in the face of disasters to integrate sexual and reproductive health, HIV and gender-based violence-related services in emergency response and recovery. Training and capacity-building were provided to UNFPA staff and counterparts in more than 100 countries. Among activities in 2009, UNFPA shipped emergency reproductive health supplies to respond to the needs of populations affected by conflict in Yemen and by floods in Burkina Faso, the Gambia, Mauritania and Senegal. In Haiti, which is prone to cyclical natural disasters, reproductive health coordinators were trained and an action plan was developed to integrate sexual and reproductive health in national emergency preparedness plans just in time before the hurricane season.

IX. Conclusion

74. The International Conference on Population and Development Programme of Action recognized that access to information and services for sexual and reproductive health, including family planning, is essential for sustainable development. The international community embraced the concept of reproductive health as an essential component of poverty reduction, which is critical to reducing high fertility and mortality and the spread of HIV/AIDS. Sexual and reproductive health information and services are especially critical to the reduction of maternal and newborn morbidity and mortality. This includes family planning, antenatal and postnatal care, childbirth services, and the prevention of STIs and HIV.

75. Strengthening of health systems is essential to ensure that appropriate, acceptable and affordable services are available to address the needs of women, men and adolescents. Policies and programmes must ensure that gender and socio-economic inequalities do not limit access to information and services. A human rights-based approach to ensure the enjoyment of the highest attainable

standard of health should inform policies and programmes.[17] Scaling up access to an essential package of sexual and reproductive health services delivered through a strengthened health system and targeting the poorest and the most at-risk population is essential to achieve health Millennium Development Goals 4, 5 and 6.

76. UNFPA undertakes a number of programmatic activities at the global, regional and country levels to reduce morbidity and mortality. The Fund promotes maternal health as part of a package of interventions in the area of sexual and reproductive health, together with family planning and STI/HIV prevention. Its Investing in Midwives programme seeks to ensure safe motherhood by providing midwives with the basic emergency life-saving skills to prevent maternal and neonatal deaths and morbidities. The Fund's Reproductive Health Commodity Security programme works with the public and private sectors to ensure access to affordable commodities for those most in need and to avoid stock outs of commodities and essential medicines. The UNFPA Campaign to End Fistula includes interventions to prevent fistula from occurring and to treat women who are affected. The UNFPA-UNICEF Joint Programme and Trust Fund on Female Genital Mutilation and Cutting seeks to increase abandonment of this harmful practice. The Fund addresses gender-based violence through sexual and reproductive health, including HIV/AIDS, programmes, and seeks to strengthen the health sector's role in addressing gender-based violence.

77. UNFPA works to reduce adolescent pregnancy and child marriage by promoting programmes that keep girls in school and build their life skills, and by providing access to sexual and reproductive health services. Through its prevention of mother-to-child transmission and comprehensive condom programming, UNFPA seeks to ensure services to prevent HIV and unintended pregnancies. The Fund provides assistance in conflict areas by supplying, inter alia, reproductive health kits to respond to emergency situations.

78. UNFPA also supports the collection, dissemination and analysis of reliable and timely health and population data that are essential to provide the evidence base for policy formulation, programme planning, and financing, especially given the current global financial and economic crisis.

79. By investing in these activities, UNFPA contributes to the reduction of morbidity and mortality, especially that caused by maternal, neonatal and reproductive causes. UNFPA maternal, neonatal and reproductive health interventions help reduce the loss of healthy years of life because of disability and premature death and contribute to the achievement of broader development objectives, including higher levels of education, economic productivity, and social equity, and help lift families out of poverty.

80. The changing aid environment calls for increased collaboration and partnerships between donors and developing countries and mutual accountability to ensure that scarce resources are used as efficiently and effectively as possible. The UNFPA strategic plan and programmes apply the principles that drive United Nations reform, including the recommendations of the 2007 triennial comprehensive policy review as well as the new aid environment envisioned in the 2005 Paris

[17] See UNFPA report submitted to the Office of the High Commissioner for Human Rights on the topic of preventable maternal morbidity and mortality and human rights for inclusion in the thematic study on the subject requested by the Human Rights Council in its resolution 11/8.

Declaration. By shifting its role from provision of project-related technical assistance to policy support, institution-building and brokering of expertise, UNFPA recognizes the growing importance of capacity development and sustainability that characterizes the new aid environment and contributes more effectively to scaling up successful country-led initiatives to meet the International Conference on Population and Development and Millennium Development Goal targets.